IN THE CIRCUIT COURT OF
THE 11TH JUDICIAL CIRCUIT
IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

MARIE J. FONTANA,

Plaintiff,

vs.

PHILIP MORRIS INCORPORATED, ("PHILIP MORRIS U.S.A."), R.J. REYNOLDS TOBACCO COMPANY, LORILLARD TOBACCO CO., and BROWN & WILLIAMSON TOBACCO CORP., Individually and as Successor to the AMERICAN TOBACCO COMPANY,

Defendants.

COPY

CASE NO. 00-1731 CA01

TRIAL

Volume 6

TRANSCRIPT OF PROCEEDINGS

in the above-styled cause before the Honorable Thomas S. Wilson, Jr., Circuit Judge, at the Dade County Courthouse, 73 W. Flagler Street, Miami, Florida, on Wednesday, March 21, 2001, at 1:30 p.m.

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(THEREUPON, the following proceedings were held:)

MR. REILLY: Judge, it's just come to our attention that the videotape editing is not complete.

THE COURT: Okay.

MR. REILLY: The plaintiffs only edited the direct of the videos, rather than the whole thing.

So, apparently, they thought we were going to edit the cross, but you can't edit -- I mean, you can't -- it's not a benefit for anybody doing that. You can't edit the direct and in a separate facility go edit the cross and stick them together somehow. That doesn't -- what you do is you just edit the whole thing.

MR. MCCARRON: Judge, I had no idea they wanted us to do their cross-examination edit. I told our guys, this is what we're offering. They, on Thursday, at some point in time, sent over their designations. We never took it up before Your Honor what was coming in, what was coming out.

The only video that we have today is --

THE COURT: Mr. Hunter said he didn't have

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all of the cross.

MR. MCCARRON: They have all of the cross on the video.

MR. HUNTER: Aren't you showing the whole thing?

MR. GERSON: They want to now object to their cross exam.

MR. REILLY: That's not right. It isn't edited. We're not objecting to our own cross. We're objecting to the portion that isn't edited. That's all.

You know what, I spent a year in trial right around the hall. Nobody has ever -- I've never even conceived of someone saying, "Well, I'm only going to edit my half and give me your half of the" --

THE COURT: You mean editing out all of the court colloquy and stuff like that?

MR. REILLY: Sure, all of the stuff that doesn't belong.

MR. MCCARRON: Judge, I can cut this short. The only videoing we're offering today because of time constraints is Hugh Fulton. That basically is the entire -- our part of the direct is edited. The cross, I think it's the

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entire cross. I don't think there was anything that was edited in that. And then any redirect.

So I don't think there is anything that can't be done today. Then everything else, I will ask the videographer tonight to go do any videos we're going to play.

THE COURT: Get that done, because I -- Reilly is absolutely correct on that.

MR. REILLY: Judge, I object to showing the cross-examination. I haven't looked at Hugh Fulton. I didn't know that they'd done this, so I haven't specifically looked at Hugh Fulton's cross to see what's in it and what shouldn't be in it. I'm happy to have somebody do that.

You're going to put Foley on first?

MR. HUNTER: No. I'm going to put Fulton on first. I'll let you know, we're going to show this tape. And we'll show all of it and we can delete what you don't want in it. You've got your designations. You know what we're going to show.

MR. REILLY: Go delete it and come back and show it. The idea they're going to play

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theirs uninterrupted and then our cross is going to have the start and stop and start and stop --

MR. MCCARRON: That's not what I'm saying, Judge. If we go to Mr. Fulton, the cross-examination starts on 8244 of the transcript. If I could just find it.

MR. REILLY: Your Honor, last night we asked for this.

MR. GERSON: I have it here.

MR. MCCARRON: And in their cross-designation, they say they're going to play the entire cross. So, the only thing -- I'm just looking at the transcript. If I could get a complete one.

MR. REILLY: Judge, there is a portion -- well, did you edit the redirect?

MR. MCCARRON: No.

MR. REILLY: You didn't offer the redirect?

MR. MCCARRON: Well, we didn't know what their cross was going to be until Thursday, and I -- to be honest with you, I didn't see it before yesterday, but I understand.

MR. HUNTER: They're offering the whole

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cross. I don't see what the problem is.

MR. GERSON: There's only one question.

MR. REILLY: I have the transcript. I see what is on it. And as long as it stops at the end of the cross, which is what Your Honor has ordered anyway, then I have no problem, because there is no interruption.

So I don't have a problem.

MR. HUNTER: Well, we now, since we want -- since they're offering their whole cross, we're going to offer redirect, which is one --

MR. MCCARRON: That's not the whole transcript.

MR. REILLY: Your Honor, we offered the cross a week -- two weeks ago, and they said, "We don't care about the cross."

THE COURT: Let me see somebody's transcript.

MR. HUNTER: There's one question on redirect.

MR. MCCARRON: That's not the whole transcript. This is the whole transcript.

MR. HUNTER: The one question on redirect. First question and first answer.

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THE COURT: That is -- I think Mr. Reilly is right, but my recollection is that when we talked about this particular transcript, you indicated you were not going to offer it.

MR. REILLY: Correct.

MR. HUNTER: Redirect?

THE COURT: Right.

MR. HUNTER: Right, but you see--

THE COURT: On Page 8229, Line 22, over to 8230, Line 6.

MR. HUNTER: Right. But, remember, Judge, what I said is I hadn't seen what they wanted to offer.

MR. REILLY: No. What Mr. Hunter said was, "I don't care what they offer. I don't care about their cross-examination."

MR. HUNTER: All right. Can I show --

THE COURT: I have to agree.

MR. HUNTER: Okay, Judge, then I won't show it. Can we not show the redirect question?

MR. MCCARRON: Yes.

THE COURT: But the other thing we're going to do is to edit the other one, complete editing.

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MR. MCCARRON: That's fine. To be honest with you, I asked Geraghty yesterday, "Did you ever cross designate -- did you designate the cross-examination?"

THE COURT: I want you to get together and get this thing done.

MR. MCCARRON: It will be.

MR. HUNTER: So we can show this without --

THE COURT: With Mr. Geraghty or whoever you're working with on the other side.

MR. MCCARRON: It's ready.

THE COURT: Now, who is the first witness?

MR. HUNTER: That's going to be this video, Judge.

THE COURT: Just the video?

MR. HUNTER: Yes.

THE COURT: What happened to the other--

MR. HUNTER: The doctor is here somewhere.

MR. GERSON: He went out to the restroom.

MR. HUNTER: This is about 23 minutes of videotape, and then I'm going to put the doctor on.

THE COURT: Okay. So are you ever going to call the two civilian witnesses?

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MR. HUNTER: No. I sent them home. They had to leave.

MR. ENGRAM: You're not calling them?

MR. HUNTER: No, I'm not calling them today.

THE COURT: That's what I meant. You mean you may bring them back some other time?

MR. GERSON: Yes, sir.

MR. HUNTER: Yes.

THE COURT: Okay. Well, let's be clear, because I had trouble understanding. When I asked you that, I meant were they coming back at any time, and your answer was no. And now we've got it clear that you're going to bring them back at a more convenient time?

MR. GERSON: Correct.

THE COURT: Okay.

MR. ENGRAM: Your Honor, I'll tell you, we've not yet had compliance with the 48-hour rule.

MR. MCCARRON: Judge--

THE COURT: It will be --

(Brief interruption.)

THE COURT: I'm sorry. Was there something else?

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MR. MCCARRON: Judge, Mr. Engram asked about the 48-hour rule. On Friday, we intend to bring Dr. Breeden and another flight attendant, but how things are going, because of the length of the cross examinations and just proceeding in trial, it's impossible to say who we're going to get to tomorrow.

THE COURT: Then give him the most liberal estimate. In other words, if you think there's even a possibility of reaching him, go two further witnesses down.

MR. MCCARRON: That's what I've been doing, Judge.

THE COURT: Okay. That will go in both directions.

MR. ENGRAM: Which flight attendant?

MR. MCCARRON: Judy Adams.

THE COURT: Bring the panel in.

(The jury entered the courtroom.)

THE COURT: Let the record reflect the jurors are all present and accounted for.

Let's proceed.

MR. HUNTER: Your Honor, at this time we'll play for the jury the videotape of Hugh Fulton.

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THE COURT: Ladies and gentlemen, the videotape deposition or any deposition that may be read in the trial and is to be considered by you as evidence in this case, the same as if the witness was testifying here live.

And incidentally, you may notice this. I have a stack of agreed orders. All I need is my signature on them so I don't have to read them, so I'm paying attention as well as signing my name.

MR. GERSON: Judge, we'd like to move the photographs that are identified in the testimony into evidence now so that we don't have to stop the tape to do that and so the jurors can see it while--

THE COURT: Any objection?

MR. REILLY: What is it?

MR. HUNTER: The photographs.

THE COURT: The photographs that are referred to in the video, I guess.

THE CLERK: These?

MR. HUNTER: No.

Doug, where are they?

MR. REILLY: No objection, Your Honor.

THE COURT: They'll go in without

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objection.

MR. HUNTER: Your Honor, with the Court's permission, at that point in the video where these photographs are described by the witness --

THE COURT: Okay.

MR. HUNTER: -- could I then at that time publish them?

THE COURT: Yes, you can.

MR. HUNTER: And then let the jurors pass them to each other?

THE COURT: Yes, sir.

THE CLERK: 1-G marked for identification for the plaintiff now becomes Composite Number 3, admitted in evidence.

(Thereupon, the referred-to document was marked by the Clerk as Plaintiff's Exhibit 3 in evidence.)

(The jurors entered the courtroom.)

THE COURT: It will take us a couple seconds to get lined up, but we'll be rolling very quickly. The good part about this is there will be no objections. They've already been taken care of, so you just get to listen straight to the testimony.

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MR. HUNTER: For the Court's information, this is approximately 25 minutes of videotape.

THE COURT: Great. Thank you, sir.

(The videotape was played as follows:)

Q. Mr. Fulton, please tell the jury your full name and where you live.

A. Hugh B. Fulton, Junior. I live in [DELETED]

Q. You're not an MD and you're not a Ph.D.?

A. That is correct.

Q. Okay. But you are an airline pilot?

A. That is correct.

Q. Where are you from originally?

A. Born in Knoxville, Tennessee, but until my dad joined Eastern Airlines when I was about -- right after I was born, and we moved here to Miami and I grew up in Miami.

Q. Okay. I want to go through your career as an airline pilot. And as I understand it, you basically worked for two airlines in your career, Eastern and United?

A. Correct.

Q. Okay. So when did you first go to work for Eastern?

A. October of 1965.

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Q. And how long did you work for Eastern?

A. Just shy of 25 years.

Q. And tell us about the types of planes you flew and in what capacity you flew them.

A. The first aircraft I was assigned to was the Lockheed l-188, known in the trade as the Electra, a four-engine, turbo-prop airplane, and I was the second officer or flight engineer, as it's commonly known.

The second aircraft was the Boeing 727. My first seat on that airplane was, again, as a flight engineer or second officer. I later flew it as a copilot or first officer for some 10,000 hours.

The next airplane was the Douglas DC-9, which I flew as captain for just over nine years. And the last aircraft at Eastern, I was in school flying the Boeing 757 as captain, and the strike interrupted my training, and that was my career at Eastern.

With United --

Q. Before you get to United, let me ask you a few questions so I'll keep the two separate. Your employment with Eastern, which is obviously much longer, and then you went to work for United.

When we use the term "cockpit" in an

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airplane, what are we talking about?

A. Well, it's the most forward compartment in the aircraft. It contains all of the flight instrumentation, systems instrumentation and switches, and used to be, in the old days, three crew members.

Now they don't make any more three-crew member airplanes anymore; they're all two crew members. And it's separated from the cabin by a door, which often has, I guess you'd call it, a pressurization relief panel, and the ability to break the door down in case you have to get out in an emergency.

Q. Now, the various aircraft which you flew for Eastern, how many passengers --

A. Well --

Q. -- do those various planes hold?

A. The Electra was the smallest, and I believe it carried 90 or 98. This goes back a lot of years. And the largest one that I flew at Eastern was the stretch model 727, which I think was about 147 people.

Q. Okay. You know, in terms of the chain of command in the cockpit, as you were going over your history with Eastern, you had been a flight

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engineer, a second officer, a copilot and then you became a captain. Obviously the captain is the highest?

A. That is correct.

Q. Okay. So when you fly, for example, now with United, in addition to the captain, who else is in the cockpit, ordinarily?

A. Just the copilot, second and first officer.

Q. Okay. When did -- we know there came a time when Eastern went out of business. What year was that?

A. The last -- the closing of the doors was January of 1990.

Q. Okay. So how long of a gap was there between the time Eastern went under and you went to work for United?

A. I joined United in May of '90. So the strike occurred in March of '89, and so I was out of work from March of '89 until May of '90.

Q. Okay. And what type of aircraft have you flown since going to work for United?

A. I started initially on the Douglas DC8, second officer, four-engine jet aircraft. Then the Boeing 737, 300/500, which was two different models

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basically of the same, two-engine turbo jet, two-pilot aircraft. And I'm presently flying the Boeing 757 and 767 as first officer.

Q. Okay. Now, I'm not asking you this question in a super technical way, but from your standpoint as a pilot and all your experience on various aircraft, tell the jury in a general way how the ventilation in the cockpit differs, if it does, from the ventilation system that the passengers and flight attendants have?

A. It does differ slightly. You have to first understand the basic principle of a ventilation system in an airplane, is you have a closed aluminium tube. Once you close the door, there's only one hole or exit for the air to leave the airplane. It's called an outflow valve, and it's generally at the back of the airplane.

So the ventilation air comes in from the engines. It's a term we use to bleed it off the engine from under the compressor section, into the air conditioning equipment, and then into the fuselage, where the people are, and then exits out of that outflow valve at the back of the airplane.

Now, the primary difference between the two compartments, the cockpit and the cabin, is that

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at some point in the regulation process it was deemed that the pilot should have more air, a greater turnover of air, in case we were to have a fire in the cockpit.

We've got a lot of electrical equipment up there. The circuit breaker panels are above and behind us. All of the electricity in the plane is concentrated there. So if we ever had an electrical fire, it's necessary we have maximum ventilation in the cockpit, so we get a little bit more air. I would say, I don't know the exact numbers, but it's probably in the vicinity of 30 to 40 percent more ventilation in the cockpit than in the cabin. Otherwise, it's pretty much the same.

Q. Okay. By the way, are you a smoker or nonsmoker?

A. Nonsmoker.

Q. Ever smoke?

A. No, sir.

Q. Now, at some point in your career with Eastern Airlines, you had occasion to take some photographs, correct?

A. That's right.

Q. Now, what did you photograph -- first of all when did you take those photographs?

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A. This was in early '80s, 1984.

Q. Okay. Mr. Fulton, when did you take these photographs? Now, the date -- the date appears -- did you put that there?

A. I did. It says February 1984.

(Videotape interrupted.)

A. As I mentioned earlier, it's a pressurized aluminum tube, and the air comes in basically at the front of the airplane and goes out of the back of the airplane. That's the only exit for the air that's pumped into the aircraft for both ventilation and pressurization.

This little door you see on the leading edge of this closes. It's in the ground position now. It's wide open because you want the airplane completely depressurized on the ground so you can open the doors.

In flight, there is so much pressure inside the airplane you can't open a door. There's too much pressure against it. As you climb up after take-off, you need to keep the cabin down close to the ground so your passengers can breathe normally.

So this door closes a little bit by little bit, very smoothly and slowly, until it's almost completely closed when you are at high altitude, and

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that generates sufficient pressure inside the airplane so that you feel like you are still on the ground and you can breathe normally.

Q. Stand here. There may be some -- if this is just a close-up or something, you don't have to go through the whole explanation again.

A. Yes. That should be. Let's double-check, because these things look similar and alike.

Yes, 727, same valve, just a close-up of that valve showing the hinge mechanism where the little door sort of slides and rotates across to close the opening.

Q. Just a different angle?

A. It's upside down. Different aircraft.

Q. That's why I'm not a pilot.

A. This is the DC-9. See the left engine. This is the main outflow valve. Now you'll notice this hole. Douglas handled the pressurization on the ground a little differently than Boeing did to assure the aircraft was never pressurized while it was on the ground.

The little door pops open as soon as the airplane lands. As soon as it takes off, it closes. This is the outflow valve where the air is escaping from the airplane during flight.

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(Video interrupted.)

Q. When you took these photographs or at any other time, did you ever smell the area of the outflow valves?

A. Well, any time you were close to it, you could smell it.

Q. And what did it smell like?

A. Stale tobacco smoke kind of a smell.

Q. Okay. Why don't you have a seat.

You took all these pictures in February of 1984. You were a pilot employed by Eastern, correct?

A. That is correct.

Q. Why did you take them?

(Video interrupted.)

Q. Let me ask you this. Were there ever occasions if the cabin were to have gotten smokey and you wanted to relieve that situation, what could the pilots do?

A. It depends on the aircraft type. On the 727, the best we could do was to turn on what we call the Gasper fan, which was an additional fan motor in the air conditioning ducts, and it made air blow out of those little overhead -- we call them eyeball vents that you could open up so you could

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get fresh air on your face, and we could do that.

Now, this 757 and DC-9 doesn't have that. On the 757, we have an option and, in fact, we have a procedure in our manual that whenever we get a complaint from the flight attendants and/or the passengers -- well, it would originate with the passengers usually -- the flight attendants would relay that to us, that the cabin air quality was inferior, because it was too smokey in the back, and we can turn off one of our recirculation fans on the 757.

Now, what that does -- maybe I should back up just a little bit. There's two very different types of pressurization/ventilation systems that old airplanes, like the 727, DC-9, the DC-8, old type ventilation system was in a sense better from a passenger's standpoint than what we have today in the newer aircraft, because today we recirculate some of that air.

In the old-fashioned kinds, the air came into the airplane from off the engines, went through the cabin one time, and it was exhausted out that outflow valve in the picture.

In the newer aircraft, 757, 777, 767, it comes in the airplane like usual, but with our

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recirculation system, we now can bleed -- not bleed the engines, but make that air go round and round, repeating its circulation through the aircraft before it goes out the outflow valve.

So it's more efficient from the standpoint of fuel consumption, but actually provides the cabin with poorer air quality.

Q. Mr. Fulton, since smoking has been banned on airplanes in 1990, do you see this anymore?

A. Not a sign of it. It's absolutely gone. The skin behind the outflow valve now is whistle clean.

(Video interrupted.)

Q. Hi, Mr. Fulton. We never met. I'm Jeff Furr. I'm an attorney that represents RJ Reynolds.

You are a pilot, sir; is that correct?

A. Yes, sir.

Q. You never attempted to measure how much environmental tobacco smoke was in the cockpit or in the cabin where the flight attendants worked, did you?

A. No, sir.

Q. You never asked anyone else to do that for you, did you?

A. No.

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Q. A moment ago, in your response to Mr. Rosenblatt's questioning, you were discussing the ventilation systems aboard aircraft, and you were explaining the differences between one-pass ventilation and recirculation. Do you recall that?

A. Yes, sir.

Q. Did you tell us that the older planes primarily used the one-pass type ventilation systems?

A. That's right.

Q. And up until what point in time was the one-pass system used?

A. It still is.

Q. Is still is?

A. Sure. On all those airplanes that are still flying, and most of them are.

Q. I believe you told us you flew for Eastern on Electras, 727 and DC-9s, is that correct?

A. That is correct.

Q. And all those aircraft have one-pass ventilation systems?

A. Yes, sir.

Q. The so the air comes in, flows through the cabin one time, and is exhausted and replaced by fresh air again?

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A. That's right.
Q. Correct. In fact, at least for the 727 and the DC-9, that happened over 20 times per hour; is that correct?
A. I don't know that figure.
Q. You're not familiar with the ventilation rates?
A. No.
Q. Okay.
A. We learn how the system operates, but we don't get those kind of numbers.
Q. You do know why manufacturers of airplanes began introducing recirculation systems, don't you?
A. I think I do.
Q. And why is that?
A. Fuel efficiency.
Q. And, in fact, they were pressured by the airlines to achieve greater fuel efficiency, and one of the ways they've done that is to introduce recirculation systems?
A. Correct.
Q. And there is a tradeoff, isn't there, between fuel efficiency and quality of air -- and air quality in the airline cabin?
A. Yes.

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Q. The more you recirculate air, the worse the quality of the air in the cabin is; is that correct?

A. If foreign contaminants are introduced.

Q. Excuse me, sir?

A. If foreign contaminants are introduced, that's true.

Q. Okay. Now, a moment ago you testified that from time to time, you would receive complaints from the flight attendants about the level of smoke in the airliner cabin; is that right?

A. That's right.

Q. And you indicated that one of the measures that you could take as a member of the cockpit crew was to -- did you call them Gaspers?

A. Gasper fans.

Q. Gasper fans. Now, there were other measures you could take, too, weren't there?

A. Depending on the airplane type.

Q. Well, all airplanes have no-smoking lamps that can be turned on by the cockpit crew, don't they?

A. That's true. Very unpopular thing when smoking was permitted.

Q. But, in fact, that was an option the

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cockpit crew had, wasn't it?

A. It was. And it was not recommended by the company, nor was it ever used.

Q. So the airline companies that you worked for recommended that you not turn on the no-smoking lamp?

A. There was no policy for it. They did not address that, but it was never recommended as a way to clear the air in the cabin. Now, occasionally some of us took it upon ourselves to do that when we had no other recourse.

Q. And, in fact, in an airliner with one-pass ventilation, in which the air was exchanged 20 times an hour, if that's correct, turning on the no-smoking lamp, assuming that everybody complied, would result in a 100 percent exchange of that air in about three minutes, wouldn't it?

A. If those numbers are true, but I have my doubts because these airplanes -- those numbers, if they're accurate, are generated on a brand new airplane with everything operating at brand new specifications. It didn't take very long in service before those specs were probably not reached because the air would not clear in three minutes. I know that for a fact because I saw it happening in the

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cockpit.

Q. So the airlines simply weren't able to maintain their ventilation systems to specs; is that what you are telling us?

A. Well, you know, there's ordinary wear and tear. Compressor blades begin to wear, and the system is simply not as efficient. Filters get clogged up. Because that air, though, is one-pass, it does go through filters and they get clogged up with foreign matter and they're less efficient as well.

Q. The reason you have filters is so they can filter foreign matter out of the air?

A. Uh-huh.

Q. Excuse me. You have to answer out loud.

A. Yes.

Q. As a member of the cockpit crew, you in fact on occasion did turn on the no-smoking lamp in response to flight attendants' complaints about the level of smoking in the cabin, didn't you?

A. That's right.

Q. Thank you, sir.

(The videotape was concluded.)

MR. HUNTER: That concludes the video, Your Honor.

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THE COURT: Who is the next witness?

MR. HUNTER: We call Dr. Michael Foley at this time.

THE COURT: Have Dr. Foley come in, please.

Sir, come on up and have a seat right here. As soon as you have a seat and get comfortable, I'll swear you in and we'll get you in and out.

Thereupon:

MICHAEL FOLEY, M.D.

been called as a witness, was duly sworn, examined, and testified as follows:

THE COURT: Please state your full name, spell your last name for our court reporter and give us your current professional address.

THE WITNESS: Michael Joseph Foley. F-O-L-E-Y.

THE COURT: Professional address.

THE WITNESS: My professional address is [DELETED]

THE COURT: Thank you, sir.

Your witness.

MR. HUNTER: Thank you, Judge.

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DIRECT EXAMINATION

BY MR. HUNTER:

Q. Doctor, I wonder if you could look to the jury and give them the benefit of your education, and first of all, may I ask you this, are you a medical doctor?

A. Yes, sir, I am.

Q. And do you specialize?

A. Specialize in radiology.

Q. Could you give the jury the benefit of your background and training in medicine?

A. Yes, sir. Well, I'll start with college. I went to Oakland University in Rochester, Michigan, and obtained a Bachelor's of science degree in biology and chemistry. From there, I went to Northwestern University Medical School in Chicago and attended that for four years, and decided to go into radiology.

I went out to the University of California San Diego for a general medical internship for one year, and then returned back to Northwestern University to do my radiology residency.

And during my radiology residency, I was elected chief resident of radiology my fourth year, which is sort of an honor among the radiology

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residents.

Then at the conclusion of that radiology residency, you're eligible to take the boards, which I took the boards and became board-certified in radiology at that point in time.

I stayed on at Northwestern University as a Fellow in radiology, specializing in CT, ultrasound and nuclear medicine, and a Fellow has the same responsibilities in a teaching capacity as an attending physician, and at the end of that fellowship year, I was qualified to take an additional board examination in nuclear medicine, which I took and passed.

And I then moved down to Tampa, Florida, where I've been in radiology practice ever since I moved down there, with the same radiology group since 1983.

One additional fact is in 1996, the American Board of Radiology offered an additional board that radiologists could take in interventional radiology, which has to do -- it's a specialized field that has to do with biopsies, angioplasties, arteriograms, things of that nature, and basic procedures. So I went ahead and took that board and passed that.

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So currently I have, besides the MD degree from medical school, I have three separate boards in radiology, diagnostic radiology, nuclear medicine and interventional radiology.

Q. Doctor, in your medical training and in medical school, on your way to becoming a radiologist, you take courses in anatomy and physiology?

A. Yes, sir.

Q. You said you did a year internship in -- I think you said a year in internal medicine?

A. Yes. The first year beyond medical school, you can go into an area of specialty, but no matter what specialty you go into, usually they require either a general year of internal medicine or a general year of surgery, if you're going to go into surgery.

Since I was going into the specialty field of radiology, I did a general medical internship at University of California San Diego.

Q. All right. What is internal medicine?

A. Internal medicine is the study of medicine and the application to diagnosing abnormalities in patients, and it's the actual contact with the patient, examining the patient, figuring out what

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tests you're going to order on the patient and carrying out those tests, getting the results of the tests, and then correlating everything, putting it all together to determine what's going on with the patient.

And so that would be the same kind of thing as if you went to a family practice doctor or internal medicine doctor; they would have done an internship year and then probably studied two more years after that.

Q. Okay. Now, you say that you're board-certified and you have three boards?

A. Yes, sir.

Q. Tell the jury what it means to be board-certified. What does that entail?

A. Well, board certification, there are two classifications of doctors out in practice, those that are, quote, "board-eligible" and those that are board-certified.

A board-eligible physician is one who has completed the requirements of a training program, and that training program has to be certified in the United States by certain agencies. And so they've completed a certified training program, but for whatever reason, they either elected not to take the

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board or they took it and did not pass.

So, you could go out and practice and not be board-certified. You would just be board-eligible.

Board certification is a test that you would take both oral and written, for instance, in radiology, where all sorts of questions from the entire field of radiology would be asked of you.

When I took the boards, you take a written examination, which is a two-day exam, approximately six hours each day, and if you pass that, then you passed your written exam and then it allows you to go ahead and take your oral exam.

When you take the oral examination, which happens at the end of your fourth year of radiology, you are examined by various specialists within the field of radiology, so you would go and sit with an examiner for 30 minutes a session, for each specialty within radiology, like chest X-rays, CT, ultrasound, nuclear medicine, MRI, angiography, mammography, GI series, IVP series, plain film diagnosis from bone X-rays, chest X-rays, et cetera.

So each of those people have an opportunity to throw as many X-rays up on a view box, and you sit and talk to them about what the

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answers to those questions are; and then they get together and decide whether you're worthy or not, basically, to be given the board certification status.

So, that's, in essence, what that is.

Q. In connection with your medical practice, have you published medical literature in the various journals?

A. Yes, sir, I have.

Q. Could you give me some -- could you give me some examples for the jury's benefit of some of the things that you've published?

A. Well, I've published both in what are called peer-reviewed journals and nonpeer-reviewed journals.

A peer-reviewed journal in radiology basically is the American Journal of Roentgenology, commonly called the yellow journal, because of it's yellow cover. And the journal called Radiology, which is a gray-covered journal.

And I published most of those articles when I was in residency and fellowship training. Some of them had to do with CT scans; some of them had to do with diagnosis of spine fractures and the various surgical procedures that could be done on

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spine fractures. Some of them were nuclear medicine topics; some of them were mammography topics.

After I graduated from Northwestern University, I went ahead and continued -- excuse me -- continued to publish in what are considered nonpeer-reviewed journals.

The purpose of that for me is if you're an internal medicine doctor and I publish an article in a peer-reviewed journal, like Radiology, you, as an internist or a surgeon or an endocrinologist or whatever, most likely are not going to be reading my literature, which would be radiology literature.

But if I publish it in a general journal that you're going to receive in your office every month, then you would get to read what I have to say regarding the field of radiology.

So once you go out into practice, it's much more effective, if you choose to publish at all, to publish things that you're interested in in journals that everyone will read in your local area that you're publishing.

So, I've done a lot of those. And I don't know how many are listed on there, but I have an interest besides chest abnormalities. I have an interest in mammography, as well; also in brain

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injury cases; people that have been in car accidents and have had brain injuries.

So I publish various topics on CT scanning and nuclear medicine scanning of people with closed-head injuries from car accidents.

Q. Have you made presentations to either the public or the medical communities about different aspects of radiology?

A. Yes, sir. I've spoken to many women's groups on mammography, and I've spoken at various clubs, Kiwaanis Club, and various clubs in my general area about those same topics that I've published.

Q. Now, Doctor, you understand that this case involves a flight attendant, who was an international flight attendant for TransWorld Airlines, began flying in 1972, predominantly on international smoking flights; continued in that occupation until December of 1996. And you understand that in this case, there is a claim that her exposure to involuntary smoking while a flight attendant caused her certain diseases and illnesses?

A. Yes.

Q. Do you understand that to be correct?

A. Yes, I do.

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Q. Doctor, I want to ask you to assume that this jury has been instructed in this case by Judge Wilson that there is a presumption that exposure to secondhand smoke, environmental smoke, is harmful to one's health. As a medical doctor, do you agree with that?

A. Yes, I do.

Q. And it can cause chronic bronchitis. Do you agree with that as a medical doctor?

A. Yes, sir.

Q. Emphysema?

A. Yes, sir.

Q. Chronic sinusitis?

A. Yes.

Q. And also COPD. What, for the jury's benefit, does that mean?

A. COPD is an abbreviation for chronic obstructive pulmonary disease. To most clinicians and to the lay public or anybody that might have COPD, it's a medical term that is virtually synonymous with the word "emphysema."

Q. Okay. Now, Doctor, I would like to ask you, if I could, to explain to the jury the -- and I want you to demonstrate this, then, radiologically. I would like them to see the X-ray evidence of this,

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but I'd like to first start with you to see if you could explain to the jury the physiology of the respiratory system that involves breathing air into the lungs and expiring the air, and the structures and the tissues involved in that process.

A. Sure.

Q. Now, in doing that, would it assist you in explaining that to the jury to use an anatomical blow-up?

A. I think we have some pictures that would help greatly. I wouldn't have to subject the jury to my drawings.

MR. HUNTER: Then let me ask, may the witness step down, Your Honor?

THE COURT: Yes, sir.

MR. HUNTER: Mr. Gerson, could you --

BY MR. HUNTER:

Q. Doctor, what I'd like for you to do is to start -- let me ask you to start -- before we get to the drawing that the jury sees, tell me the purpose of the hairs in my nose, the nasal passages and the mucous blanket and -- what's the medical term for your throat?

A. Pharynx.

Q. Explain those elements and the purposes of

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how they help us as human beings breathe and whatever.

A. Okay. Well, obviously we all know that we have hair in our nose, and we probably know from going to science classes and so forth, that in you -- you have mucous membranes inside your mouth and going all down your throat.

Some of the mucous membranes within your nose and in your throat, as you get down from the pharynx, which is just beyond the mouth cavity or oral pharynx, and coming down into the trachea, some of that mucosa has what they call cilia on it.

Cilia are tiny, little hairs that have the ability to beat and have a muscular contraction to them.

And the purpose of that is when we breathe in air, there can be particulate matter in air that you can breathe, and as you breathe it in, if you have nothing blocking that particulate matter, it could make it all of the way down in your lungs and just begin to plug up your lungs after a while.

So, obviously, we need to try to filter the air out as much as we can. The way that God designed us, basically, is that you would have hairs in your nose to act as a filter. You would have

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mucous membranes, where they would be wet and moist and would be able to pick up particulate matter, and you would have a ciliary action with all these little, tiny hairs within the trachea and bronchi, that when they received particulate matter, they could beat it back up in your throat; you could cough it up, blow your nose, whatever the case may be, to get rid of this stuff inside of your lungs.

Q. Are coughing and sneezing defense mechanisms of the body to get rid of things --

A. Yes. Yes, they are. I mean, that's what an awful lot of us probably do many times a day, without really realizing it, clearing your throat, where you may feel like you have a little bit of mucous. If you analyze that mucous, it would contain particulate matter, and the natural mechanism for most people, if they are not going to spit it out, would be to clear their throat and they have some mucous in their throat and they swallow it. That's a normal mechanism that all of us do every day, and that's all part of the purification process that we would -- that we would do as human beings.

Q. Now, what do you have in the drawing here, the first one?

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A. Okay. Well, this is just -- and I'm sure the jury is very familiar with this basic anatomy, but obviously just to go over to be thorough, we have the trachea up here, so we're beyond the oral pharynx in the mouth cavity. Coming down, this would be the larynx or voice box right here, essentially, and we would have the trachea. And the trachea has these characteristic ringed cartilages that come down, and eventually, when the trachea ends, it will divide into two, into a right bronchus and a left bronchus.

This division point right here, for instance, is called the carina. And you can see this on a chest film.

This is the chest cavity. We see the lungs, and we see the lungs are protected by the rib cage. We've got the clavicles at the top, the first rib through the 12th rib. We can't -- the 11th and 12th ribs are not attached to these junctions, which are called the costochondral cartilages. These from ten up, all hook back up to the sternum.

So this allows some ability for your lungs to get compressed, and yet the rib does not snap or break unless it's severe because of the cartilage which provides a spring-like action to the rib cage.

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We have the diaphragm right here, which is along the bottom part of the lung, and it's a thin sheet of muscle, basically, which your brain can control.

You can tell yourself, I want to take a deep breath in, and that diaphragm contracts and holds down. The negative pressure is created on the inside of your pleural cavity, and your lungs expand and you pull air into your lungs.

Q. When I breathe in, is that the diaphragm that is actually doing the work?

A. Most of it. Part of it is the diaphragm, and also in between the ribs are intercostal muscles, and that also helps pull things and expand things so it will allow your lungs to expand.

So this is the basic anatomy here. We've got -- this is the same way, by the way, that you would look at the chest film, is you look at a chest film as if you were looking at the patient.

So whenever you're seeing a lung over here, even though it's on your left side looking at the patient -- this is the patient's right lung, obviously. You would have the heart right in here and then the left lung.

Typically, the right lung is a little bit

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larger than the left lung because the left lung is smaller in this region because of the heart that is in this position.

So we have the basic airway anatomy, which is oral pharynx at the top, at the mouth, coming down into the trachea, with the ringed cartilages, coming down to the carina, which is at the end, this V-shaped area is the carina, and then branching into right -- right bronchus and left bronchus.

Q. Now, yesterday when I was speaking with the jury, I referenced a -- I said that if -- I said there's a bronchial tree that truly looks like the branches of a tree?

A. Yes.

Q. Do you have something that could show us that?

A. I do. So we'll go ahead to this next picture, and we'll take away the lungs for a second, just put them away for a second, and look at this compilation of tubes here, which we see, which is called the bronchial tree, for obvious reasons; it actually looks like a tree in the wintertime with no leaves on it. And this is basically the outline of the anatomy of the bronchial tubes that lead into the lung.

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Eventually, on the next picture I will show you the end stage of what actually the lung tissue itself is composed of, but these are the main airways that get the air out to the lungs and allow the lungs to exchange the oxygen you breathe in to get it into the bloodstream, and it also is the main airway that allows the air that you're breathing out, it contains the CO2 that you're trying to get rid of out of your body, to come back out, all in the same system. So the good air comes in, bad air comes out, the bad air being the CO2.

The basic outline of this, as we talked about the carina, which is right here, coming down from the trachea, this is called the right main stem bronchus, left main stem bronchus, which are labeled here; and then we have the upper lobe bronchus on the right, the middle lobe and the lower lobe on the right; and then these are further divided, such that you could look at the right middle lobe and see that there is a lateral segment to the right middle lobe, which is right here, and there's a medial segment to the right middle lobe.

And similarly, each of these branching areas of the upper, mid and lower lung zones have various specific branches.

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For instance, in the right lower lobe, this is called the anterior basal segment, and this is called the lateral basal segment, posterior basal segment, and medial basal segment.

These are all very specific names, so if I was trying to guide a pulmonologist to tell him where he needs to go to do a bronchoscope, put a scope down there and biopsy a tumor, I could say that it appears that that nodule is arising or is near the anterior basal segment of the right lower lobe, and he would know, when he comes down here, that he needs to go all of the way down to the right lower lobe, and then turn out here and turn up here, and he would be right near where the tumor or suspected tumor is.

But this is -- this is the basic subway system, if you will, of the bronchial tree, and it does look like a tree with its various branches. And it's very specific, both for the left lung field and the right lung field, of all of the various segments.

Q. Now, what are the structures that actually communicate with the bloodstream to allow for the CO2, which that's carbon dioxide --

A. Yes, sir.

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Q. -- and the oxygen going to the blood and the CO2 to come back out, what pictures show that?

A. We can go to the next picture, and that will demonstrate that.

If we go further out -- and this drawing is kind of nice because it does show a little bit more complication in what's going on -- we have the bronchus coming down, and now we've got superimposed on that some of the other things that you would see if you actually dissected a lung and looked at it under a microscope.

We have arteries and veins. The arteries are obviously going to be carrying the oxygen that you have in your system to run by these small lumps that we're seeing here.

What are these small little lumps or berry-looking type structures? That's called alveoli. The alveoli is the end terminus of the bronchi. The bronchi branches eventually out into the lung sacs, which are called lobules and each lobule contains multiple acini.

And these little sacs are called alveoli or acini, same terminology.

Q. Let me ask you this. This structure that I'm putting my fingers on, in reality, how big is

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that?

A. It's super tiny. You cannot see an alveoli or anything of that nature typically on a regular chest film because it's less than a millimeter in size. They're very, very tiny.

But perhaps this whole lobule you may be able to see as a one- or two-millimeter structure. But as you can see, this is containing 10 or 12 alveoli per lobule.

But the point that I wanted to make is somehow, some way, when we breathe in, how does that air get into your blood, how does oxygen get to your blood so it can go to your other organs?

Well, this is the actual level at which oxygen is exposed through the alveolar wall to the tiny capillaries of arteries and veins where the diffusion takes place, where the oxygen actually diffuses across the wall into the alveolus into the artery or vein, and is then carried throughout your body.

And, obviously, you know, a very simple example of what would happen if someone is choked --

MR. REILLY: I object, Your Honor. It's nonresponsive to the question.

THE WITNESS: Okay.

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MR. REILLY: Well beyond nonresponsive.

THE COURT: Sustain. Ask the next question.

BY MR. HUNTER:

Q. What would happen if someone was choked?

A. I was just trying to make the example, if someone was choked way up high at the trachea, obviously you're not allowing air to come down the trachea, come down the bronchi, get down into the branches and eventually exchange at the alveolar level. That would be one form of blockage.

The other form of blockage would be if you have blockage at the alveolar level itself; in other words, what if the alveoli are plugged up because of pneumonia or debris or whatever that allows this diffusion and exchange not to take place, that would be another form of blockage that would not allow air to get into your blood system.

So this is the basic anatomy, going from the outside of the lungs, seeing how the lungs are situated in the chest cavity, going to the bronchial tree, seeing how that all branches out throughout the lung field, and then going down to the smallest sub-units that we can identify and that are recognized, which are called the alveoli, and this

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is where the actual exchange of oxygen takes place and carbon dioxide is gotten rid of out of the body.

Q. Doctor, have you had an opportunity to examine X-rays of Marie Fontana?

A. Yes, I have.

Q. I would like at this point in time if you could demonstrate through X-ray, and you can do this the way you believe you think it would be most understandable for us, to demonstrate upon your review whether, in addition to changes that Marie has demonstrated radiologically, that may be related to her sarcoidosis.

A. Okay.

Q. Do the X-rays indicate, do we have objective evidence from X-rays that she has airways disease that is consistent with exposure to secondhand smoke in the cabin of the airplane, that I would ask you to assume she was in for 20 years with transAtlantic flights, smoking flights, all prior to the ban of smoking on airplanes?

MR. REILLY: Objection to the form of the question.

THE COURT: Overruled.

BY MR. ROSENBLATT

Q. Doctor, Mr. Gerson has these X-rays.

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In chronological order, tell us.

A. Okay. Can we move this just a little bit this way, because I think I wanted to show them on this, as well.

MR. GERSON: Okay.

THE WITNESS: Because I may be able to show them some things a little bit better, as far back as we can get it. Okay.

BY MR. HUNTER:

Q. And if you wanted to pick that up and walk with it, Doctor, feel free to, because I want the jury to see what you see.

A. Okay. The films that I'm going to show you are predominantly chest films. We do have some CT scans of the chest.

MR. REILLY: Excuse me, Your Honor. Can we have a number on this, Your Honor, for the record?

THE COURT: I don't see why not. It's dated May 12, '89, correct?

MR. HUNTER: Yes, sir.

THE COURT: Okay. We'll put that down.

MR. REILLY: It should be marked for identification, as least.

THE COURT: Take these and mark them for

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identification, Plaintiff's --

THE CLERK: Yes, Judge, they're part of the X-rays.

THE COURT: Then mark them whatever the X-rays are, then mark them subparts.

THE CLERK: The X-rays are Composite Number 2 for the plaintiff, admitted into evidence. These are copies. Do you want me to mark them?

THE COURT: A, B, C, D.

THE CLERK: Okay.

MR. REILLY: Thank you, Your Honor.

THE COURT: Thank you.

A. I'm going to try to show you also on this T.V. set, because I think you'll probably be able to see it better than even on these films. But let me just start with this first.

This was one of the earlier films.

MR. REILLY: Could I --

A. I was shown --

MR. REILLY: Excuse me, Your Honor. I hate to interrupt. For the record, could you tell which one you're talking to the jury about now? That's what I'm getting at now.

THE COURT: That would be number A.

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That's the first one listed.

A. I'll identify the date.

Okay. One of the first films that I was shown was from 5/12/89, and this is a frontal view of the chest that I picked out to show you here. And just to review some of the normal anatomy again as it relates to a chest film, so we can see how everything fits together, here is the bony structures.

First of all, here is the clavicle, right clavicle and left clavicle on each side. These are the ribs that we're seeing going all of the way down. Here is the first rib, second rib, et cetera, swinging all of the way down.

We can see parts of the shoulder out here. This is the scapula. You see the heart outline right here. This would be the right ventricle over here and left ventricle over here.

We're seeing the spine through the mid portion of the chest. This mid portion of the chest, by the way, you may hear the term occasionally mediastinal. The mediastinum means basically mid portion of chest.

This is where a lot of vital structures in the chest live. This is where your aorta comes off

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from the left ventricle and makes a turn and goes down.

These are called the hilar regions. This is where the pulmonary arteries branch out from the top of the right ventricle and go to the right side and left side, so this opacity here you're seeing are the hilar regions.

Then all of the black areas that you're seeing are the lung fields. This is the diaphragm, right diagram. This is the left diaphragm. This is some gas in the gastric fundus of the stomach right here below the left diaphragm.

What we're seeing on these films is these hila appear enlarged, and there are several things that are contained within the hila.

The hila have the pulmonary arteries, as I said. They also have the pulmonary veins, but they also have lymph nodes. So that's basically most of what is in a pulmonary hila.

When you see a hilum that is enlarged, you usually have to be concerned about enlarged lymph nodes. And that could be one of the first signs of cancer.

And in this person, you happen to notice that the hila are enlarged on both sides, so there

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is bilateral hilar adenopathy.

BY MR. HUNTER:

Q. Hilar adenopathy, what does that mean?

A. Hilar adenopathy means bilateral enlargement of the lymph nodes, and adenopathy means enlargement of the lymph nodes.

If I go too fast, slow me down and I'll explain that further.

This soft tissue fullness over here would be considered right peritracheal fullness, which would again be suggestive of adenopathy along the right tracheal air column.

We can see the trachea right here, this black area that we're seeing coming down is the trachea, and we'll probably see that better on some additional films. I see the combination of right tracheal and hilar adenopathy. That is a configuration that is suggested to be somewhat or even characteristic of a disease called sarcoidosis.

And this ultimately, we did find out that this patient does have sarcoidosis.

So looking back at it and knowing what we know about sarcoidosis, one of the first ways that you can diagnose it radiographically is to see the hilar lymph nodes and the peritracheal lymph nodes

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both enlarged, and that would be consistent with sarcoidosis.

What I've also done, and they tried to do it on the picture, and I don't how well it's going to show up for you, but I can show it either way, is in each of these chest films, I asked them, would they please blow up the right lower lobe, just as -- as a sample area that we can look at that in more detail.

And so they have done that in this picture here, and that is that.

And I asked them to blow it up two times, and the reason I asked two x's is because two x's is the magnification of a magnifying glass that a radiologist would typically use if he wanted to look closer with one of those big magnifying glasses.

I think that you can probably see on here that there are focal, blacker areas -- and I'll point these out, just some of them -- scattered all about.

And can everyone appreciate those, or should I try to show you on this T.V.?

MR. REILLY: Judge, I would object, Your Honor, to asking the jurors questions.

THE WITNESS: I just wanted to make sure

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that they're able to see with the light.

THE COURT: Sustained.

Doctor, do whatever is best you think so that people can understand.

THE WITNESS: Okay.

A. (Continuing) I'm just going to try to see if I can show you this also on the T.V. screen here.

This film is a little light. Let me bring it down. That helps. That's even better.

Okay. That's about right.

If we look at this, here is a black area of lucency, a black area of lucency, black area right here.

Notice there's like a little white dot in there.

I don't want to ask the question and upset the other attorneys, so I'll just say it.

I see a lucency here with a little white center in it. This is a very characteristic finding in patients who have emphysema. And emphysema means enlargement, or hyperaeration of specific areas.

Now, that's like a little cystic cavity, and these lucencies are small, little holes, basically, in the lung, which are focal areas of hyperaeration.

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If I wanted to talk about that with a more precise medical term, rather than just using hyperaeration or using the word emphysema, a more precise way of talking about that to perhaps a pathologist would be to say the word centrilobular emphysema.

Centrilobular emphysema means a focal air sac that you can see, and in some of these you can even see a central white dot in them. Here's another one here with a central white dot.

We could probably see these better with the lights down. I don't know if that's possible or not.

THE COURT: Just a second.

A. But that is a key finding in emphysema, and in this specific finding, and I think that does help quite a bit.

Here is another one, a lucency, and see the central dot in it right here -- this was the other one I was showing you, lucency with a central dot in it. Here is another one up here, lucency with the central dot, right there. Lucency, central dot.

These are all characteristic, all of the way through, of centrilobular emphysema. Here is

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another nice one right here, lucency with a central dot right there.

And, you know, viewing this from 20 feet away is probably not the most optimal way to do it. Obviously, if you're reading this chest film, you have much better resolution looking at it at 18 inches away than looking at it at 20 feet away, but I think that the findings show well enough.

The reason why I bring this out -- here is another one right here with the central dot, right there. The reason why I bring it out is because centrilobular emphysema is a very characteristic finding that you see in people that smoke.

And it is a very characteristic finding, and I -- when I was asked originally to interpret this chest film, and I did it actually on my deposition last week, I mentioned that I felt that this patient's lungs were hyperaerated. Hyperaeration, to me, means I'm looking at the extent of the lungs, top to bottom, and just getting a general impression that they look a little bit more inflated than what I would expect.

And hyperaeration is another word that could be used or implied to mean emphysema or early COPD change, chronic obstructive pulmonary disease.

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But if you study the lungs further, you can actually see these small areas of lucency that compose the larger area that I feel is hyperaeration, which is called centrilobular emphysema.

Q. Doctor, let me ask you a very simple question. If you saw this lung film in this area, would you say this was a smoker or nonsmoker?

A. I would say they're a smoker, and as I've discussed before, in just the vernacular, I would look at that chest film, and it appears to be what I would call a, quote, "dirty chest."

And a dirty chest I would be calling several things: One, I'm seeing peribronchial thickening, which means that the mucosa of those bronchial branches that I was showing you are thickened -- the mucosa is the tissue inside the bronchus -- is thickened from inflammation, and so when I see a combination of peribronchial thickening and centrilobular emphysema, I feel that it is very characteristic of a person that smokes.

And we see this, you know, obviously all of the time because many times the people that we end up getting a chest X-ray on isn't a person that has no problems; it's a person that does have a

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problem and may be having some problem one way or another. And many of those patients that we examine are smokers.

So, anyway, I'll stop there and proceed on.

Q. Let me go on chronologically.

THE COURT: For the record, so it's clear, that is 2-A.

MR. REILLY: The date on that, Your Honor, is 5/12/89.

THE COURT: Right.

The fill is dated 1/21/90?

THE WITNESS: Correct. I'll put this film up on the board, as well.

MR. HUNTER: 2-B.

THE COURT: 2-B.

A. And, obviously, again--

BY MR. HUNTER:

Q. Let me just stop and go with me a little bit. We're now, what, about six months farther ahead in time?

A. Yes.

Q. Okay.

A. This film is from 1/29/90. Again, it's a frontal view of the chest.

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Getting familiar with some of the anatomy now, again, we're seeing the enlarged hilar regions. In fact, this left hilum looks maybe even a little asymmetrically larger than the right side because of this prominence over here.

We're seeing heavy peribronchial thickening in the mid and lower lung fields. And we don't see any definite consolidated infiltrates, per se; do not see any fluid in the lungs.

And just to try to take advantage of the T.V. set to make sure people can see things well, and I think that's pretty good -- let me change this.

And, again, looking at this, we're seeing these characteristic lucencies, or little holes, and almost everywhere you look you can see them.

They're everywhere that your eyes want to look. If we look a little bit higher, we can see them. And these, again, are those centrilobular areas of emphysema.

You can go over on to the other side and see them, the lucencies scattered about, and this is what you can see if we're looking up close.

Also I want -- let me demonstrate this, if it will show up, magnified up as best we can -- I

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don't know if this can be focused any better. It seems a little blurry.

MR. HUNTER: Do we have a technician?

A. But I think I can see.

MR. HUNTER: Let's just get it the best we can get it.

THE WITNESS: Is that about as good as it gets.

THE VIDEOGRAPHER: Yes, actually.

THE WITNESS: Leave it on auto. Okay.

A. (Continuing) What I wanted to show you, look at this lucency. And do you see this white density that's projecting beyond the margin of the lucency?

As I change my pen around, it's driving the auto focus crazy on this machine.

There is a white tissue softness or whiteness that you can see branching off along the margin of this lucency and extending down along the bottom.

Where it's a little bit thinner here, you can see a little bit more of a thin white line. Then it gets thicker, very thick here, and going all of the way around to the other side, to the 7, 8 o'clock position, all of the way to 12, 1, 2, 3,

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thinning out to the 5 to 7 o'clock area here.

This is what I would define as peribronchial thickening, where you're seeing actual soft tissue thickness surrounding the bronchus.

Now, peribronchial thickening, the reason I bring it out is because when you inhale something into your lungs that is irritating to your lungs, the response of the mucosa that lines the bronchi is to become inflamed.

And just like any other part of your body, say the heel of your foot, if it's rubbing on the back of your foot and it gets inflamed and you begin to blister the back of your heel, the mucosa of the bronchi can get irritated, as well, by things that you breathe in.

And if it gets irritated, that would be a condition called acute inflammation, or the medical term would be acute bronchitis. It means that the bronchi are inflamed, and the "itis" means inflammation.

If that becomes persistent, day after day, week after week, month after month, it's no longer acute, it's chronic, meaning long-standing.

Q. How about year after year?

A. And if you take that further, if you go

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year after year, that chronic inflammation and soft-tissue thickening that you're seeing around the bronchus can turn into a permanent area of thickening called scar, so you can get peribronchial scarring around the bronchus.

And so the purpose in me talking about the lucencies in the lungs, these holes that we're seeing here, is to talk about the centrilobular emphysema which you can see in smoking.

The purpose in talking about peribronchial thickening is that you actually are seeing the result of irritation to the bronchus, and if that persists long enough, it can go through the stages of going from acute to chronic, to permanent, which would be scarring.

And I think as we look at more and more films, I can demonstrate that to you on every film.

Q. All right. But before we go on, I want the jury to understand, where are our bronchial tubes?

I want to walk over to this picture here. This is the dark area that you've been describing here?

A. Yes, sir.

Q. Is that a bronchial tube that is actually

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coming towards the jury, like a pipe that's looking at them; they're looking down a pipe?

A. Yes, sir.

MR. REILLY: Object to form, Your Honor.

THE COURT: Overruled.

A. When you're -- when you're seeing a circle, you're obviously seeing the circles of the bronchi that have been -- that you're looking at on end or down the barrel, almost like down the barrel of a shotgun or something like that.

You can really tell by looking at that down the barrel of a shotgun, if you're looking down the barrel from the front, or if that bronchus is going away from you and you're looking down the barrel with it pointing in the opposite direction.

But you can tell by looking at this bronchial tree diagram that a majority of the bronchi are going out to the sides, because they have to cover the lateral width of the lung.

So, when you look at a chest film, one might wonder, well, how come I can see a lot of those round lucencies more towards the center but I'm not seeing many of them towards the periphery. That's because a lot of the bronchi are heading laterally, either lateral to the front or lateral to

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the back, to cover the entire area, to feed all of the different areas of the lung.

But the ones where you can demonstrate peribronchial thickening the best are the -- are the tubes that are either coming out straight at you or straight going away from you, because you can identify these nice, little circles and then you can follow very nicely the margin of the circle and look for the soft tissue thickening around the circle, around the bronchus.

Q. Now, is that peribronchial thickening consistent in your medical opinion, Doctor, with exposure for, at this point in her life, over 15 years of exposure to secondhand smoke?

MR. REILLY: Object to the form, Your Honor.

THE COURT: Overruled.

A. Yes, it is.

Q. All right. Could we go on now sequentially through time and show the jury, so they can see what the X-ray shows.

THE COURT: Is that 1/3?

A. The next film we have is 1/13/92.

THE COURT: That's 2-C.

A. We can look at this all different ways.

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I've got a laser pointer. I don't think it will offend anybody if I use this, will it?

MR. REILLY: Objection, Your Honor. Again--

THE COURT: Overruled.

A. (Continuing) I can use a pen or pointer. If it's far away, I might use the light pointer just to make it easier.

But, again, on the chest film, we, again, can notice the bilateral hilar adenopathy, the enlargement of the hilar regions which means enlarged lymph nodes.

Q. The hilar adenopathy is something you associate with sarcoidosis?

A. Yes, sir.

Q. Okay. We can see the soft tissue thickening all along -- and I think this is actually a good example where we can see the tracheal air column well. Do you see this lucency we're seeing up here? This black lucency, this is the tracheal air column coming down.

You can still see it here, and now you can actually see it branching off to the right and branching off to the left. This would be the carina, then, where the bronchus branches, and we're

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actually seeing the air within the right main stem bronchus through this soft-tissue adenopathy that we're visualizing here.

So, again, seeing a characteristic finding of sarcoidosis, which is right peritracheal and bilateral hilar adenopathy. We are slowly noticing that.

It's a little bit difficult to show the jury, because we don't have a panel of view boxes like I might have in my office, where I could line up '89, '90, '92, '94, '96 and you could just take your eyes and go from '89 to '96 or '89 to '94, so it's almost like you have to store some of this in your memory banks as you're looking at it.

But slowly we're seeing this in the patient's lungs, and we'll see as we go on persistent peribronchial thickening throughout her lung fields, persistent centrilobular emphysema throughout her lung fields, which I feel very strongly is consistent with a smoker's lung.

Q. Now, you understand, she never smoked?

A. Yes. I mean, I understand that after. You know, from the beginning --

Q. She never voluntarily smoked?

A. Correct. Correct. But needless to say,

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the result is the same in the lungs field. It does the same thing, because you're breathing stuff in whether you have a cigarette to your mouth or you're breathing it. It does the same thing eventually.

MR. REILLY: Objection, Your Honor.

THE COURT: Overruled.

A. (Continuing) And so what I was trying to say here is I'm seeing persistent changes of findings that one would expect radiographically from smoking, and those two main findings are peribronchial thickening, as I said, which is the irritation phenomena to the bronchus, and the centrilobular emphysema, which actually is a destruction of a collection of those alveoli, and that's why you see those cystic changes.

Okay. When those tiny, little, thin septated walls of the alveoli break down into that collection of alveoli, it's just a cavity, then, With not all of the little lobules present anymore, those little air sacs that we saw, which are the alveoli. When those begin to disappear, you're left just with a cystic cavity, and those little cystic cavities are the things that we're talking about. Those holes are the centrilobular emphysema.

On top of this, we begin to see, as the

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patient goes further and further along in the years, her sarcoidosis is progressing, as well. And we begin to see greater interstitial changes.

So with each one of these chest films that I show you, I kind of want to get you feeling for what you're seeing out in the peripheral lung fields, because that is what we have to take into account, both phenomena.

For instance, see these linear --

Q. Let me slow you down. You used the term, I think for the first time, "interstitial"?

A. Interstitial. Okay. You're correct.

Q. What does that mean?

A. Interstitial, if I look back to the one picture -- if I go back to this one picture, the interstitium of the lung is like a fibrous network of the lung, in which everything within the lung is supported.

So, we've talked about one support structure of the lungs, which are the bronchi branching out. Another potential structure --

Q. Those are the airways? Bronchi are airways?

A. Bronchi are airways.

The other thing we would be seeing are the

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basically rotting away on the inside. That's as opposed to a TB granuloma, which is caseating on the inside. It eventually turns to a -- to a thick kind of fluid, and the easiest term I could think of is it's basically necrosing or rotting away on the inside. That is a caseating granuloma; whereas, sarcoid granulomas, the little, tiny nodules that can develop in the interstitium, are called noncaseating.

But what happens with this patient over time is we begin to see changes in the interstitium which we really did not appreciate in the very early film, in 1989. Where you begin to see these linear white opacities or densities within the interstitium bring changes of sarcoid. So we have two things happening at once.

We have, I feel, changes of smoking effect going on in the lung, and we have sarcoid changes going on in the lung.

And one of the things that we can see that are evident as changes in sarcoid are these linear opacities, which are interstitial changes, which are different than, for instance, this lucency here, which is centrilobular emphysema, and which is different than the peribronchial thickening that we

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talked about before that you can see when you magnify a certain area up, and you can see in any of these areas increased soft tissue thickness surrounding this lucency right here, and increased soft tissue thickening surrounding all of these lucencies.

Going completely around this, you can see the thickness in here.

Look at this one, how thick this is right here. That's got a thickness from there to there, surrounding that centrilobular lucency.

So, this is -- this is the difficulty one might have if you're looking at something for the first time that you have two things going on at once, changes of smoking in the lungs and changes of sarcoidosis in the lungs.

I just wanted to make sure that they were understanding that's going on.

Q. Well, let me ask you this, Doctor. As a medical doctor, is there any reasonable medical doubt in your mind that she has two disease processes going on as demonstrated in these films?

A. No. No. None whatsoever.

Q. All right. Go on to the next -- are we through here? Can we go on?

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A. Yes. I think so. And I think as we go into further films, we'll see a dramatic change in the lungs.

THE COURT: Is this 11/6?

MR. HUNTER: 11/6/95.

THE COURT: 2-D, D as in dog.

A. Okay. And I think this is probably -- maybe not the first time, but it's at least, for demonstration purposes, one of the easiest jumps in films where you can see a change going on. And let me just put this film up, put this in your memory bank for a second.

Notice all of these lines and opacity that you're seeing, and kind of what they describe as a ground-glass appearance, kind of like a haziness seen throughout the lungs. Let's look at that.

And then let's go back to the earlier film where things look blacker. We're not seeing as many lines. We are seeing some down here at the bases, right down in this area, but we're seeing almost like focal lucencies, almost like a figure eight right here, and larger areas of lucency over here.

Notice how we're seeing more predominant lucency in the mid and upper lung zones here than in the lower lung zones.

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Q. All right. Now, you're the one you're pointing to with your finger now is what date?

A. That is 1/3/92. And I want them to remember --

Q. All right. That's the other-- the last film.

A. The last film.

And then let's go back to this film.

Q. She's flying three more years?

A. Right. We went to 11-6-95 and I think we could easily see when we do that -- if we had these up together, it would be easier for me than shuffling films back and forth, but I think we can see there is a definite change when we go from this to this.

Q. I want you to do that twice more so that people who were writing can see it again.

A. Okay. So this is the 1/13/92, and we can kind of focus for our purposes in the mid and upper lung fields on both sides, and we see that. And then we go to this (indicating).

Q. All right. Now --

A. One more time. That was the 11/6/95.

Here, again, is the 1/3/92. We go now to 11-69-5 and we see greater interstitial opacity

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happening.

So in my mind, what's happening to this lady here, well, the lungs look worse, first of all. I think anyone can see the lungs look worse. There's more whiteness to the lungs. There's more interstitial changes to the lungs, which I would ascribe to sarcoid changes.

However, I don't know what I did with my little pointer here. We can see, if we zoom up on this a little bit, that we're still seeing all of these persistent changes that I would ascribe to smoking.

We're seeing scattered, numerous -- I mean, everywhere -- I can just move my pointer randomly and stop, and there is a focal lucency, focal lucency all over the place, littler ones, bigger ones, bigger ones, small one, small one, larger one. They're all over the place. A big area of lucency right here.

They're scattered all over the place. This is centrilobular emphysema, scattered all over.

Then if you take any specific area and analyze it any further, like let's take this lucency right here, for instance, see the soft tissue thickness? Let's look at this one over here. See

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that there is an actual width that could be measured.

These -- the lung -- normally, you should not see anything but the most thin white line, almost immeasurable. And here, you know, I could definitely make my red marker go from the inside to the outside, and you could measure that. That is too thick.

Q. What is lucency?

A. Okay. The lucency is -- normally when an X-ray goes through the lung, if there's nothing to stop it, it will hit the X-ray plate on the back of you, and turn the silver halide crystal on an X-ray plate to black.

So if you have mostly air-filled structures, as in the lungs, the lungs are going to make a darker picture on the X-ray than bones, for instance, because the bones, when the X-ray hits it, it doesn't penetrate through the bone so well, so it cannot expose the silver halide on the film and it makes it white then.

Q. When you say "lucency," that means to me black?

A. Yes, sir. And what we're seeing are -- they're basically air cysts or air cavities. That's

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what those round black holes we're seeing. That is the lack of normal lung tissue.

We're seeing a thickened wall, which is the peribronchial thickening, and we're seeing the centrilobular holes, which is the centrilobular emphysema.

Q. Let me ask you this. It seems obvious her sarcoid -- or you tell me, is it obvious her sarcoid is progressing at this point?

A. Yes. I think -- I think this was a good example, and that's why I wanted to flip the films back and forth a couple times, where we're seeing more interstitial things happening, but we're seeing a permanence of things that I would attribute to smoking, which would be the emphysematous changes, the centrilobular emphysema and the peribronchial thickening.

Q. Now, how can you -- how can you say that the -- that the peribronchial thickening and the emphysematous changes are not related to her sarcoid?

A. Well, they don't cause those kind of phenomena.

The predominant change in sarcoid is the hilar adenopathy and the changes out in the

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interstitium. So that's the way you would separate the two.

Ultimately, as you can see here, if you have nodules laid down in the interstitium, and those nodules go from the middle and all of the way -- abut up against the bronchus, pretty soon air going to -- everything will be all mixed together, and you won't -- you know, when a person becomes end-stage of both diseases, it all looks like horrible lung; but where we can dissect it out better are on some of these earlier films, in this '92, '95, '96 range.

By the time we get out to the 2000 films, she has so much going on, if you gave that chest film to a person and say, "Dissect everything out for me," it's like a flood of information; it just all blends together at that point.

Q. This jury is charged with the responsibility of trying to determine, if they can, what amount of her damages is an aggravation of an existing condition, that being sarcoid. What evidence do they have in these films to do that?

MR. REILLY: Objection, Your Honor.

THE COURT: Overruled.

A. Well, I think we've been seeing that all

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along, is that we're seeing emphysematous changes in her lung from early on, and it is not only present on films later, but it's progressing, as well. We're seeing more holes, more lucency, peribronchial thickening that is more prominent, easily seen on the mid and later films, compared to the earlier films.

Q. All right. Let's move on in time. What do we have next?

A. I think the next one we have is 9/9/99.

THE COURT: That would be 2-F. 2-F, 9/9/99.

MR. HUNTER: 9/9/99, Your Honor.

THE COURT: That's 2-F.

MR. REILLY: We have a 2-E already?

THE COURT: 2-E is 12/26/96.

THE WITNESS: I think 12/26/96 is the CT scan.

THE COURT: It is.

MR. HUNTER: You're right. We'll get to that in a minute.

THE WITNESS: Okay.

BY MR. HUNTER:

Q. Now, at this point, she's almost two years since she's flown. I want you to assume there will

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be evidence received in this case, accept this as a hypothetical, that in December of 1996 she ceased to fly; she was admitted to the hospital with coughing up blood.

A. Okay.

Q. And never flew thereafter.

A. All right.

Q. What does this film show us?

A. Well, I think the jury -- well, I won't say I think the jury anything.

What we can see on this film, 9/9/99, is that there is one predominant new finding, and that's this finding right here. We're seeing a rounded opacity in the level upper lung field that wasn't there to any significant degree before.

Ultimately, this nodule, if you will, this mass, was proven to represent a fungus ball, sometimes referred to, if you biopsy or get a tissue sample of it, was an aspergilloma, which is a specific kind of fungus, and it exists in a cavity in the left upper lobe.

So this area has -- of the lung has become so poor and has cavitated out so much that an actual fungus ball has grown in the left upper lobe, and this was proven in the medical records and so forth.

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What we're -- what we're seeing, and I guess I will move over to this T.V. set to show some of this, is we're seeing still greater interstitial change, which I would attribute to the sarcoid. These linear opacity that we're seeing are changes in the interstitium, and there's a very fine network of interstitial changes that are really hard to resolve on this kind of T.V. set from 20 feet away.

But it is there, and it is very impressive. Each time we take another step in time on the chest X-ray, it's even more impressive, which means a progression of the sarcoid.

However, the thing that's also more and more progressive is we're seeing not only persistent lucencies, but the lucencies that we're seeing are larger and larger.

For instance, if -- let's look at this area right here. This is in the right suprahilar area. And we go back to this film. We see scattered lucencies here, which are changes of emphysema, which I would ascribe to smoking. I don't see any large focal lucency in that area.

Then let's go to this film, which is 9/9/99, and now I do see some large focal lucencies. And over here and over here. Large area. Scattered

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lucencies, which are large in the left mid lung field.

And we know that this large lucency or cavity developed a mass in it, which was proved to represent a fungus ball.

So that is progression of emphysematous change, cavitary change, et cetera, that is occurring in the lung; and I, again, would ascribe that it's a combination of both disease processes happening at once in this patient, that has known sarcoid, but has another disease process happening, which is going on simultaneously and marching along and getting progressively worse as the other disease process is marching along and getting progressively worse, as well.

Q. But if she stopped flying in December of 1996, why wouldn't she get better as far as the airway disease or the emphysematous change or emphysema or chronic bronchitis; why wouldn't it get better?

A. Right. Well, once you have progressed from acute inflammation to chronic inflammation to scarring, scarring does not go away; scarring does not get better.

It's almost like getting a scar on your

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face. You can scrub your face as much as you want, but that scar is still there; and it's the same with peribronchial scarring around the bronchus. The peribronchial thickening has turned into a scar. The cavities that are present, the emphysematous change, the holes in the lung from developed scar around them, and it's just-- it's not going to get better. It tends to either stay the same or get worse with time.

Q. All right. Doctor, take your seat and let me ask you a couple of questions concerning our next series of films.

A. Okay.

Q. Doctor, let me show you what has been -- Madam Clerk, this is?

THE CLERK: Plaintiff's 1, composite.

Q. Let me show you, Doctor, what has been marked as Plaintiff's 1, composite, which is a composite set of medical records from several admissions of the plaintiff in this case. Calling your attention to the Department of Radiology services report of 12/23/96 --

A. Okay.

Q. -- and ask you if that report references the CT scans of chest -- Your Honor, I'm showing the

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witness now CT scans of the chest, two documents dated 12/23/96.

THE COURT: That's 2-E.

Q. Is that the report, first? That's my question. Is that the report that corresponds to these CT scans?

A. Yes, sir, it is.

Q. Now, Doctor, I'd like to preface this with my next question, with this statement, that it was suggested to this jury yesterday that there was nothing in the medical records indicating that there was chronic obstructive pulmonary disease in Ms. Fontana.

I want to suggest that the exact quote to the jury was: "If you go to a doctor and he's a specialist and he's a lung doctor and he does these tests and he treats you and he treats you for five or six years, the plaintiffs would like you to think that they just -- that -- the doctor just ignored it; that he didn't pay attention to it, or maybe that he thought she had chronic obstructive pulmonary disease or chronic bronchitis or emphysema and he just didn't write it in the records. Now, isn't that a little foolish?"

I want you to suggest that that was said

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to this jury yesterday by the lawyers for the defendant.

Now, I'm showing you a blow-up of the record that you have in front of you. Is that correct?

A. Yes.

Q. And isn't this, in fact, the radiologist's report that was prepared in 1996, that corresponds to these CT scans?

A. Yes, it is.

Q. Okay. This lawsuit was filed in, I want you to assume, the year 2000.

In fact, the diagnosis of the doctor at that time was severe COPD?

A. Yes, sir. That's correct.

Q. So if it was suggested to this jury that the medical records did not show COPD, five years before this lawsuit was filed, that would be inaccurate?

A. That would be incorrect.

Q. Okay. What do you think, now that you have the record, that radiologist five years ago -- well, let me ask you this.

In your experience, have you been retained as an expert in court cases before today?

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A. Yes, I have.

Q. Have you been retained to evaluate the conduct of radiologists?

A. In medical malpractice cases, yes.

Q. Have you ever testified on behalf of a patient and against a doctor?

A. Yes, I have.

Q. All right. Five years before this lawsuit was filed, I would like you to explain to the jury, within the field of radiology, that statement that Dr. Gardiner, I believe his name was, is it borne out on these CT scans, and if so, show this jury how and where?

A. I'm getting out the corresponding picture.

THE COURT: Do you want me to turn the lights down?

MR. HUNTER: Do you want the lights on or off?

THE WITNESS: Let me find it first, and then we can turn it down.

Okay. I think I've got the same picture.

BY MR. HUNTER:

Q. Now, before you start, this doesn't look anything like the last pictures, so what's different about it?

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A. Well, this, I'm just giving you a little brief explanation.

We're now converting, shifting gears and moving from chest X-rays to CT scans. And a CT scan is a wonderful tool for looking inside the person's body without needing to cut them open, basically.

And the way a CT scan works, I'll just give you a little explanation so we can understand the orientation, the way everything is, is a patient is laid flat on a moving bed that goes inside of a doughnut hole, which is the CT scanner, and the hole itself is called a gantry.

And probably everyone has seen a picture of an MRI scanner or a CT scanner where they have the bed. The patient lays flat on their back and the body moves inside this hole or gantry.

On the outside of that hole and inside the case of the CT scanner is all of the workings of that CT scanner; and one of the main components is it has an X-ray tube on one side of the patient and an array of detectors on the other side of the patient.

So when the CT scan is taking a picture of you, it fires an X-ray beam through the hole, with the patient in the middle, and whatever information

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is collected is collected in that array of detectors on the other side of the hole.

And the way a CT scan works is that X-ray tube will go around the patient 360 degrees, firing continuous X-rays around the patient, back and forth; and each time it makes a rotation, that person's body is moved a small increment further and further inside.

So what's happening is that the X-ray tube is taking a slice and it's taking another slice, and it's taking another slice, as the patient's body is moved through the scanner.

Then all of this information that is gathered by the computer for each CT cut is put together and put into a two-dimensional picture, and that's what this two-dimensional picture is.

Well, we have one up here, is this CT slice. And the way it is oriented is it's oriented that this is the front part of the patient, or anterior; this part down below is the patient laying on the bed. And you're actually seeing the little cushion of the bed right here. This is the person's back right here. This is the person's scapula, and this is their left side, marked by an L right here, so left side, right side. And we're actually seeing

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pieces of the rib.

Now, notice we don't see the complete rib on each slice, and the reason why you don't is because when the slice was taken, the ribs are moving at an angle and you're only catching a portion of that rib. So you're not following it along the length of the rib.

But here's a rib, a different rib, a different rib. Here is the sternum. This is the central part of the chest, which we talked about, is the mediastinum, where the ascending and descending aorta are.

All of this soft tissue fullness that we're seeing are the enlarged lymph nodes in the hila and right peritracheal region.

See all of this fullness? This is left side, right side. This is right peritracheal fullness here, and you're looking at the lungs and the markings that we can see inside the lungs.

Q. All right. Now, stop.

In other words, we're looking at the lungs as if we were looking from the feet up or the head down?

A. And that's a good point. The other orientation that people should know is, if you

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picture me flipped up with my feet, the soles of my feet facing you, that is the orientation of a radiologist or a person looking at this CT scan. So this is my right side, and I would be flipped up. Someone would cut through my chest, say, on a CT scan, throw away the bottom part, and you're looking right up into my chest so that you're seeing my right side, left side, my sternum, my spine in the back, my scapula back here. And so it's just flipped right up and you're looking right in as if you were standing at my feet, with each slice.

And what the CT scanner is basically doing is it's bread-slicing the loaf of bread, the person's body, so slice, slice, slice. And each slice is being held up for you to look at, seeing what's going on. Here, put that slice down, next slice comes up, and that's what each of these slices are on the CT. So it's a very intricate and detailed way of looking at the lungs.

And, also, the other thing that the jury should know is that there are two different standard ways that the images are photographed.

This is called a lung window setting. And what it does is it basically blots out the detail of the mediastinal, so we're really not seeing the

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margins, for instance, of the aorta that well, but it's a window, which is basically like adjusting the contrast, so we're seeing all of the marking in the lungs well.

Then they shoot these same pictures again changing the window level, which is basically the CT term for contrast, and you don't see these lung markings so well, but you see the detail in the mediastinal and the soft tissues as well.

Both sets of those pictures are presented to the radiologist to read. But for the interest of time and so forth, we're showing you the lung window settings, but I could easily show you the mediastinal settings, if you wanted, as well, because we have both.

Q. Well, what I want to know, we were saying yesterday we were going to walk through the medical records. Now, walk through -- what is this severe COPD that was seen by the treating physicians two years before this lawsuit was ever filed?

A. Right.

Q. What do we see here that corresponds to that?

A. Well, what you're seeing is a general lack of branching vascular markings in certain areas,

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which is over here, and we're seeing all of these cystic areas, which is the centrilobular emphysema, and its focal areas of hyperaeration within the lung. And we can probably refer to one of these just as well.

This one is good.

Look at all of these changes that we're seeing. All of these large lucencies.

Now, another term that they made here during the course of the trial is this -- this shows it even better because now we're -- you can appreciate the fine markings. And we see both things going on.

Do you -- I won't ask the question.

You can see, or I can see fine, linear markings, which are the increased interstitial markings of sarcoidosis.

We can also see thick septations and thick soft tissue density around focal lucencies, and the thickening is the peribronchial thickening and the focal lucencies are the cavities, the lucencies that are produced by the emphysema.

So when the radiologist reads this, he is looking at this and he is seeing emphysema, severe emphysema, because it's scattered throughout the

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lungs.

Q. Now, he says COPD here. Is that the same thing?

A. Yes. It's a synonymous term. Severe COPD, severe emphysema.

Q. Now, do you believe that that is related to her involuntary smoke exposure, or is that something that may be, in your opinion, the sarcoidosis finding?

A. I think that the findings -- all along the COPD has been there; the emphysema has been there. And as things progress, you're just getting further destruction and further emphasis of both entities happening, the interstitial change of the sarcoid, the hilar adenopathy of the sarcoid, the peribronchial thickening of the smoking and the emphysema of the smoking.

So everything -- the whole milieu is getting worse and worse on each set of pictures.

The CT brings it out particularly well, because it's -- it's such a detailed analysis of the lungs.

Q. All right. Doctor, you may take your seat.

My partner told the jury that the

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sarcoidosis, and that type of disease, is something that affects your ability to breathe in; whereas emphysema affects your ability to breathe out. Is that a fair statement?

A. That's correct.

Q. You understand that Marie Fontana is awaiting -- she wears a beeper, and she's awaiting a call for possibly lung transplantation?

A. Yes, sir, I do.

Q. Can you say, based upon your review radiologically of the progression of both her diseases, the sarcoidosis and the other diseases which you relate to her involuntary smoking, can you say if she didn't have either, what would that mean to her -- to her status? In other words, if she didn't have the changes that are related to smoking, would she need the transplant, in your opinion?

A. In my opinion, I think she wouldn't. I think she would have severe sarcoidosis, and in my opinion, from a radiological opinion with clinical experience in the background, I think that the smoking has tipped her over the edge, if you will, where she may have been able to survive the rest of her natural life with her sarcoidosis, but she has had another thing introduced that has been an

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irritation to her lungs, which has taken a toll on her lungs, and is basically not allowing her to exist with her known disease of sarcoidosis as she otherwise might.

Q. Doctor, if you had a patient who had sarcoidosis, not you, but you're a medical doctor, would you recommend that they be in a -- that they avoid tobacco smoke in the air?

A. Absolutely. I mean, it makes common sense, I think.

Q. Doctor, this is an X-ray of February 6th, of this year.

Just show the jury, if you would, how is this --

MR. REILLY: Can we have the number on this?

MR. HUNTER: February 6th.

THE COURT: February 6th is 2-H.

A. It's the same thing here, as well.

Okay. I think that what you can see on this film is this nodular mass has gotten somewhat larger than on the previous film that we looked at. It almost looks like we're seeing a lucent septation in the middle, as if this mass is divided into two.

This is some opacity up in the right upper

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lobe, as well, which looks like it's either an infiltrate or perhaps a developing mass on the other side.

It's hard to tell basically from the chest film. We'd probably like to get a CT of that and check it out.

I think what this blow-up area of the right lower lobe is showing -- we'll just go to that and see if we can see this a little bit better -- is we're just seeing a progressive increase in interstitial markings in the lungs, but progressive increase in lucency throughout the lungs, as well.

So we're having more emphysematous change throughout, but also more interstitial change throughout the lungs, as well.

And these lucencies are beginning to coalesce, so when your eye first looks at it, you just see a large area, for instance, of blackness, which is this air densities, these cavities, this lucency, the holes; and when you first look at it, you see there is a whole zone here of lucency, but when you actually stop, and if we analyze it further, and I try to -- try to do it with this T.V. set, you can actually see this large zone of lucency is composed of multiple cavities and cystic areas of

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various sizes scattered throughout the lung fields that is accounting for this.

And that would be very typical, as I said before, of the emphysema, and I think that is very consistent with the way the radiologists originally read that CT scan back in '96 when he said severe COPD. That's what that is.

MR. HUNTER: All right. Thank you, Doctor. I have no further questions.

THE COURT: Ladies and gentlemen, it's about 3:25. I think it would be appropriate to take about a five or ten minute break to let you stretch and let the defense get a chance to see what they want to do.

So if you'll just leave your note pads on the chairs and come back up here in ten minutes.

(The jurors exited the courtroom.)

THE COURT: Doctor, you're not supposed to talk to the attorneys about your testimony. You can talk to them, but you can't talk to them about your testimony.

THE WITNESS: Okay. Thank you, Judge, for telling me.

THE COURT: Yes, were you ready? I guess

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we are.

MR. MCCARRON: Judge, we're just going to steal your court reporter for a second about the 48-hour notice.

I just want to put something on the record. On Friday, to be conservative, we're also going to give the notice for Gail Pheling, and the only evidence that we'll be using with Ms. Pheling, if any, will be photographs of Ms. Fontana.

MR. HUNTER: The other statement wasn't on the record, the initial designation of Dr. Breeden.

MR. MCCARRON: Dr. Breeden, we'll be using medical records and X-rays. And then also Judith Adams, who is a flight attendant, and I don't believe we'll be using any evidence or exhibits with her.

MR. ENGRAM: Thanks.

MR. MCCARRON: The only thing we could possibly use with her are the seats, the airplane seats, but I don't really see that.

THE COURT: Okay. Let's go.

(The jury entered the courtroom.)

THE COURT: Everybody have a seat, please.

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Let the record reflect all our jurors are present and accounted for, and we're ready to proceed.

Mr. Reilly.

MR. REILLY: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. REILLY:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Doctor, let's begin --

MR. REILLY: Good afternoon, ladies and gentlemen of the jury.

Q. Doctor, let's begin with how you come to be with us today.

You began doing medical/legal work about 13 years ago; is that correct?

A. Yes.

Q. 14 years ago?

A. Correct.

Q. And today, you gave us your professional address as [DELETED]

is that correct?

A. Right.

Q. You actually have a couple of professional addresses, don't you?

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A. Correct.

Q. What's your other professional address?

A. Well, there's several of them, as you say. You could list each hospital that I'm on staff as a professional address, and that would include Manatee Memorial Hospital, Brandon hospital, where I'm the chairman of radiology at; the University Community Hospital, and University Community Carrollwood.

And all of our offices, we have three offices, and we have the fourth office that you did my deposition at, which is on DeSoto Avenue in South Tampa.

Q. Finally got to it, didn't we? The office on DeSoto, that's an office you attend once a week, correct?

A. Yes, sir.

Q. And that's where you handle your medical/legal cases, right?

A. Correct.

Q. And once a day -- I'm sorry -- once a week, every week, that's where you are, working on medical/legal cases, correct?

A. Well, that's not the only thing that we have there, but that is what I go there once a week and handle whatever is there.

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Q. All right.

A. We do outside reads at that office, as well, from other imaging centers that are mailed in or sent in.

Q. And you have a special corporation through which you do this legal issues work, correct?

A. That's not a special corporation. It's part of Sheer Ahearn and Associates, which is the name of our radiology group.

Q. It's called Radiographic Consultation, isn't it?

A. It has a separate name, but it's not been incorporated or in any way separated from Sheer Ahearn and Associates, Radiologists.

Q. There's --

A. There's no separate tax ID number or anything, for instance.

Q. Within your group of radiologists, you've created a special group called Radiologic Consultants, correct?

A. Radiographic Consultations.

Q. Radiographic Consultations?

A. Correct.

Q. All it does is this medical, legal work, right?

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A. No, that's not correct.
Q. That's the majority of what it is; isn't it?
A. That's not correct.
Q. Well, people go to this office on DeSoto once a week to do the work of Radiographic Consultations, correct?
A. Correct. But that is not correct, what you said before.
Q. And, Doctor, you review about 100 medical/legal cases a year, right?
A. Correct.
Q. And you've been doing that now for 13, 14 years?
A. Yes, sir.
Q. And you charge $350 an hour to review films, just to look at the films, right?
A. Correct.
Q. Please answer audibly so the court reporter can take it down.
A. I was waiting for you to finish your question, but I'll answer you audibly, of course.
Q. Okay. You've testified a lot in court, right?
A. Yes, sir.

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Q. All right. As a matter of fact, you testify 25, 35 times a year?

A. Not in court, no. I think probably about a dozen times in court is accurate.

Q. A year?

A. Yes, sir.

Q. And how many depositions do you give a year?

A. Probably the other number that you said. Anywhere --

Q. 25 to 35 depositions a year?

A. Anywhere -- anywhere from two to three times the number of court appearances.

Q. You charge $600 an hour to give a deposition, right?

A. Correct.

Q. And you charge $3,000 for a half a day of testimony?

A. Correct.

Q. But you've been here all day?

A. Correct.

Q. So you're charging $6,000 for today?

A. Correct.

Q. And because it's expected that your direct examination and cross-examination will go over into

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tomorrow, you'll charge another $3,000?

A. Yes, sir.

Q. Okay. You haven't reviewed all of the medical records in this case, have you?

A. No.

Q. Pardon?

A. No.

Q. These are all of the medical records in this case, aren't they?

A. I have no idea. I have not reviewed them all.

Q. That Exhibit 1 Mr. Hunter gave you -- where is that?

THE CLERK: Right here.

Q. Did you compile this?

A. No.

Q. Did you have any involvement in the preparation of this?

A. Of those particular papers?

Q. Yes. The selection of all of those medical records, have you had any involvement in the preparation of Exhibit 1?

A. I would say some, yes.

Q. Well, so did you take out from all those medical records, did you take out all the

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radiographic interpretations by all of the doctors who have looked at chest X-rays or CT scans of Ms. Fontana?

A. I did.

Q. And are they all in here?

A. I have no idea. I didn't compile that. I pulled out from my records that I was sent all of the X-ray dictations that I could find.

Q. Well, I took your deposition just a week ago, right?

A. Correct.

Q. And then how many radiographic interpretations did you have?

A. Back then?

Q. A week ago.

A. I had no idea. I didn't count them.

Q. Well, didn't we look at them?

A. I don't think you ever found any of them for me. I asked if you had a copy because you -- because you kept asking me questions about the dictations rather than what I thought about the films.

Q. Uh-huh.

A. And rather than paging through a million pieces of paper, I felt like if you wanted to ask me

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questions directly about those dictations, if you want to ask me that, then show me the dictation and I'll answer a question.

But after the deposition, I figured since you put such an emphasis on the dictations, I took the time to page through all of my records and find all of the dictations.

Q. For the jury's benefit, the dictations are the statements, the interpretations of the radiographs by the radiologists and pulmonologists. Radiologists are guys just like you and the pulmonologists are doctors that actually treat patients with lung problems, right?

A. Yes.

Q. And the pulmonologists read a lot of chest films, don't they?

A. They may look at them but they don't interpret them; a radiologist interprets them.

Q. Well, don't radiologists interpret chest films, too? I'm sorry. Don't pulmonologists interpret chest films, too?

A. Well, I would agree with your first statement. The radiologist does interpret the chest film, and they are the ones that provide the medical document that's on the chart that you see.

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A pulmonologist is certainly welcome to look at it, but in most hospitals, a pulmonologist does not have the right to read that chest film. The radiologist does.

Q. Doctor, don't pulmonologists have radiographic equipment in their offices oftentimes?

A. Yes.

Q. And when a patient comes to a pulmonologist's office, doesn't the pulmonologist, if he thinks -- he or she thinks it's appropriate, ask the patient to go over and have a chest film done right there?

A. Yes. That's true.

Q. And don't they then review those chest films and make interpretations of them?

A. That's correct.

Q. And don't they write in their medical records, right then, dictate right then their interpretation of the radiographs?

A. Yes.

Q. All right. So pulmonologists do make interpretations of radiographs, don't they?

A. But not in the context that I'm talking about, in this case. In this case I'm talking about all of the dictation that I have pulled are

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radiology-dictated, dictations by a radiologist, not by a pulmonologist.

Q. Okay.

A. And those are the official medical records that were obtained from the various hospitals where this patient has been.

Q. And did you bring those -- all those radiological interpretations by radiologists from hospitals with you today?

A. I did.

Q. Do you have them with you today?

A. They're in my backpack.

Q. All right. When did you put that all together?

A. Over the weekend.

Q. When did you get all those records?

A. They were there when you did the deposition.

Q. You didn't produce them at the depositions, did you?

A. They were all sitting there. We didn't take the time to go through them. You started asking me questions and not really allowing me to find them, and I asked if you had copies of them, and you did not want to show copies to me, but

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continued to ask questions about them.

Q. I prevented you from reviewing the radiographic interpretations during the course of your deposition?

A. You kept asking questions, and I did not have them separated out into a separate pile at that time. I don't think you physically held my hand, but you certainly kept asking the questions so there was no time to spend time looking for them.

Q. Doctor, have you looked at -- Doctor, didn't I mark all of the medical records you brought to the deposition?

A. I think you did.

Q. I think I did, too.

And didn't the Court reporter put it down in the deposition, every exhibit that I marked?

A. I believe so.

Q. And I'm going to hand you the cover page to the deposition, and I'll ask you if you'll read to the jury what it is that the court reporter marked, in terms of exhibits to the deposition.

A. Exhibits marked for identification: Number 1, letter from Doug McCarron; 2, medical records from Dr. Coopersmith; 3, medical records from Jackson Memorial Hospital; 4, medical records

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of Dr. Coopersmith obtained through subpoena.

Q. Now, that's all of the medical records you brought to the deposition, isn't it?

A. Yes.

Q. That is a huge, far cry from all of the medical records, isn't it?

A. I have no idea what volume of medical records there were. That's all I was given to look at the films.

Q. That's right. That's all Mr. Hunter's office gave you to look at, were those medical records that you've just identified, correct?

A. Right. I really didn't even need those. I could just look at the films alone.

Q. I understand that. That's normally what you do?

A. Correct.

Q. You just take the films, put them on the view box, and give an interpretation right on the spot of what you see, right?

A. Exactly.

Q. So when you say you had the radiographic interpretations by the radiologists that you now have in your backpack, the truth of the matter is you do have in your backpack radiological

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interpretation from 1989 now?

A. No. I've never seen the 1989 interpretation.

Q. You've never seen -- have you seen them from 1990?

A. I'd have to pull out dictations to look at them. I don't know what dates they are, but they're the ones that I found in the set of records you and I had at that deposition sitting on the table.

Q. Doctor, let me ask you something. Do you know when Dr. Coopersmith first saw Ms. Fontana?

A. No.

Q. Do you know what year?

A. I have no idea.

Q. Do you know what decade?

A. No, I don't. It was not -- it was not important for me.

Q. Do you know when Ms. Fontana was first diagnosed with sarcoidosis?

A. I didn't finish the previous answer.

Q. I'm sorry.

A. It was not important for me to know any of the treating physicians. It was important for me to look at the films and make a radiographic interpretation of those films.

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So it was not important, whether it was Dr. Coopersmith or Dr. Ben Casey who saw this patient. It was important for me to look at the films and make an interpretation of them.

Q. Dr. Ben Casey didn't look at this lady, did he?

A. I have no idea. I'm giving you an example.

Q. Doctor, can you identify --

MR. HUNTER: Judge, with all due respect, I'd like him to answer -- to allow the witness to answer before he asks the next question.

THE COURT: Would you give him a chance to answer the question?

MR. REILLY: I'm sorry. I apologize.

BY MR. REILLY:

Q. Doctor, can you name any radiologist who interpreted any films of Ms. Fontana in 1989?

A. Not off the top of my head, no. I'd have to look at the report.

Q. How about -- you don't even know if you have such a report, right?

A. Well, we could get them out right now if you'd like to look at them.

Q. Doctor, I just wanted to know what you

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know.

A. Okay. That's fair.

Q. How about 1990, can you identify the name of any radiologist who interpreted any films of Ms. Fontana in 1990?

A. Not that I know of. I wasn't finished answering.

Q. I'm sorry.

A. It wasn't important to me to know the name of the radiologist who interprets any of the films. It was important for me to look at the films and make my interpretation, because when someone sends me a film, they're not asking me what someone else said, they want to know my interpretation of the film.

Q. You weren't interested in the interpretations that the radiologists who were caring for the patient, who were involved in the patient's care, had to say at the time they interpreted the films, right?

A. I looked at those interpretations, but I did not look at them with the same intensity that I would if it were a medical/legal malpractice case where I'm either defending what a radiologist said or not defending what the radiologist said.

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And I had no idea when we did my deposition that you would be grilling me on whether I did or did not read the radiologist -- read the radiologist's interpretation and know what their names are and know the exact wordings that they used in their interpretation.

Q. Doctor, you know what, if any, radiologists interpreted any radiology, any chest X-rays or CT scans of Ms. Fontana in 1991?

A. You just -- you asked me the same question, and I will tell you, for every year, I do not know the name of a radiologist off the top of my head. We could look at them, and it's not important for me to know -- as a matter of fact, the one interpretation that Mr. Hunter blew up that said "severe COPD" that he showed to the jury, that says "severe COPD," I have no idea what the radiologist's name is on the bottom of that, even when it's been blown up. I did not look at it. It was not important to me.

Q. We'll get that.

A. That's fine.

Q. If you have radiographic interpretations in your backpack now, when did you get them, if you didn't have them a week ago at your deposition?

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A. I had them a week ago.

Q. Then why didn't you produce them during the course --

A. Well --

Q. -- when I asked you for them?

A. They were all clipped together in those big black clips, and I put everything on the table for you, and that's what this lady wrote down.

Now, it was not separated out, radiographic interpretations. They were included in all of the medical records that were laying on the table for you and I to go over page by page, if we wanted to, but we did not do that.

Q. Doctor, have you looked at the medical records from Brookdale University Hospital?

A. I have no idea.

Q. Have you looked at the medical records of Drs. Monahan and Jurado?

A. I don't believe I did.

Q. How about medical records of the pulmonologist, Drs. Mark Adelman and Kenneth Baron?

A. I don't know if I did or not.

Q. How about the medical records of Dr. Jonathan Greene?

A. I don't believe so. It's not familiar.

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Q. Do you know who Dr. Jonathan Greene is?
A. No, that's why.
Q. Do you know whether he treated --
A. That's why I said it's not familiar; I don't recognize his name.
Q. Do you know what he treated Ms. Fontana for?
A. No.
Q. Do you review the records of the Bethesda Memorial Hospital?
A. Not that I recall.
Q. Do you know when Ms. Fontana was hospitalized there?
A. No.
Q. Did you review the medical records of Dr. David Schwartzwald?
A. No.
Q. Do you know why he saw this lady?
A. I have no idea.
Q. How about the medical records of the West Boca Medical Center?
A. No.
Q. Do you know why she was there?
A. No.
Q. How about the Boca Radiological Group, did

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you review any records of that group?

A. We have to look at the reports that I have to determine if that's one of the groups that read.

Q. How about Holy Cross Hospital, did you look at any records there?

A. That sounds like a name that's familiar.

Q. Do you remember when Ms. Fontana was in Holy Cross Hospital?

A. I think one of the X-ray folders that we had had a lot of films from Holy Cross, and there was a whole list of chest X-rays, and I'm not sure if that's when it began, from '89 into the '90s or mid '90s going forward, but do I remember seeing that name.

Q. How about the North Ridge Medical Center, did you ever review any medical records from there?

A. That's another name that's familiar, but I don't know the exact dates.

Q. How about Dr. Niurka Alley?

A. Not familiar with their names.

Q. How about the Boca Raton Community Hospital?

A. I'm not sure one way or the other.

Q. Do you know when or why she was there?

A. Not sure.

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Q. Do you remember, Doctor, that I asked you during your deposition whether you'd looked at the reports of the radiologists, the people who had interpreted the radiology -- either radiologists or pulmonologists, and you didn't know whether you had or not?

MR. HUNTER: Page and line?

MR. REILLY: 116, Line 14.

Do you have a copy of this deposition for him?

You've got it.

BY MR. REILLY:

Q. Doctor, read for me, if you would, starting on Page 116, Line 14:

"Listen to the question.

"Answer: I'm trying to tell a point to you."

MR. HUNTER: Before you start out with "Listen to the question," I think the jury needs to know what the question was so that they --

THE COURT: That's the traditional way. Give him the question and answer and ask him if he remembers it.

MR. REILLY: Well, that is the question.

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If you listen to the answer, then you'll see how this works, Your Honor.

MR. HUNTER: Well, Judge, if you start out a question by, "Listen to the question," then you don't know what the previous question was.

THE COURT: Let's go back to the previous question and start from the beginning. I think that's called the doctrine of completeness.

MR. REILLY: Well, I started with, "Doctor, what" --

THE COURT: I'm sorry. Fine. Go to the question.

MR. REILLY: So what you're saying is -- that's what I said. Well, we have to go way back, then.

Q. "Are you saying that the reason why there's no comment by the radiologist who interpreted the 1/29/90 X-ray is because they may not have observed the peribronchial thickening that you observed?

"Answer: No. They may very well have observed it but simply lumped it together in their overall assessment of the findings that they're going to report on the chest films.

"Question" -- this is how far back I have

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to go.

"Question: When you say 'lumped it together,' how would they lump it together?

"Answer: In whatever they had to said. You don't -- if I say -- if I read a chest film as congestive heart failure, okay, I can look at that film and say there are increased vascular markings consistent with congestive heart failure, or I can say there are increased vascular markings and increased interstitial markings throughout both lung fields consistent with congestive heart failure, or I can say there is an enlarged heart, left pleural effusion and curly V lines at both lung bases consistent with congestive heart failure. All those findings can be consistent with congestive heart failure.

If someone reads a chest film that has curly V lines at the basis of the lung fields, among other findings, and he didn't mention curly V lines, is his report incorrect? No."

This is how far back I had to go.

"You said this is congestive heart failure."

I said, "Doctor what" --

And your answer was: "So what you're

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saying is if a person looked at this, I would say if that radiologist read that 1/29/90 film and compared it to the 5/12/89 film and thought that that chest X-ray shows no change, I'd say they're in error."

And my question was, "No change?"

And you interrupted me and said:

"Answer: There is a change."

And I said, "No change in the appearance now of peribronchial thickening, right?"

Your answer was: "No change in the appearance of those lung findings compared to 5/89.

"Question: That's not the question I asked you, though, Doctor."

Your answer was, "I'm not -- I'm not --" And I said, "Listen to the question."

And your answer was, "I'm trying to tell a point to you, because you're now relating it back to what did that radiologist say, and I'm not here to tell you what that radiologist said. I don't know any of these radiologists, and" --

MR. HUNTER: "Don't know what."

Q. "I don't know what any of these radiologists have said anymore because I haven't looked at the reports for a month or two. I'm telling you what I'm saying about these chest films.

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"Question: In fact, Doctor, you've never looked at the report of 1/29/90, have you?

"Answer: I don't know if I have or not. I don't have them here with me."

Now, you didn't have them with you that day, did you?

A. No. That is not correct. I did have them with me.

Q. Well, which time were you telling the truth, Doctor, here when you said, "I don't have them here with me," or today when you say you did?

A. The truth is I don't have them with me in the sense that I don't have them pulled out to look at. They were in those packs and I found them, going through those packs.

I asked you further back if you had a separated-out pile of films, and you either had it and didn't want to produce it or didn't want to produce it at all.

But I thought that if you want to ask questions about the chest X-ray reports, let's get the report out and ask it, and then you began asking questions about did you read the report of whatever, 1990.

I have no idea if I read that specific

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report because I know I didn't have the report from 5/89, so I didn't know whether I had or didn't have the report of 1990. And it had been a couple months since I had looked at those reports.

And as I said before, it wasn't important to me, but apparently it was to you, to be very up-to-date and know each and every word that the radiologist had said in those reports.

I would have been very happy to have gone through every page of the things that we had sitting on the desk and find those reports.

Q. Doctor, did you look at the treating physician's records for any of the care and treatment of Ms. Fontana?

A. I may have, but I don't recall who that treating physician is. Again, it was not important to me as a radiologist. I wasn't asked to look as an expert from the treating physician's standpoint; I was asked to look as an expert, as a radiologist looking at these films.

Q. Did you ever look to see what diagnosis the treating doctors made of Ms. Fontana at any time?

A. Only in a cursory way, looking through the reports, not to verify it with whatever I thought

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was going on radiologically.

Q. In your examination of the -- your cursory review -- "cursory" means hardly at all, right?

A. I flipped through it to see if there was anything about X-rays on those reports. There was sarcoid mentioned throughout most of the reports. I saw pulmonary function tests had been done on the patient. I saw that she had a bronchial artery embolization at one point. I saw that she was treated with steroids; a lot of things that went on with this lady, none of which were of concern to me.

She had had a previous cholecystectomy that wasn't a concern of me, even though you can see it on the chest films; you can see the surgical clips in the right upper quadrant. Those were not things that were medically pertinent to me.

Q. Doctor, in your review of the medical records of Ms. Fontana, did you ever see any doctor diagnose her with emphysema?

A. Treating doctor, so you're separating that away from the radiologists who said COPD?

Q. Did you ever see a treating physician, somebody taking care of that lady, diagnose her with emphysema?

A. I had no idea because I did not look at

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the medical records for that. As I said, I looked at the medical records for the radiology involved with her case.

Q. Doctor, did you ever see -- let's not get ahead of ourselves.

Doctor, let's talk about sarcoidosis. No one knows what causes sarcoidosis, do they?

A. Correct.

Q. No one knows what causes sarcoidosis to progress in people, do they?

A. Correct.

Q. Sarcoidosis commonly occurs in black females, doesn't it?

A. Yes. Very high prevalence, about 10 to 17 times greater prevalence than in a Caucasian woman.

Q. No one knows why, do they?

A. That's correct.

Q. It is those very same black women in whom the disease most frequently progresses, isn't it?

A. Correct.

Q. And no one knows why?

A. That's correct.

Q. There isn't a cure for sarcoidosis, is there?

A. Correct.

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Q. There is treatment, but oftentimes it doesn't work?

A. Correct.

Q. If you are one of those unlikely black women in whom sarcoidosis progresses, it can progress to end-stage or Stage 4, can't it?

A. Yes. There's specific progression and remission rates for each of the stages.

Q. And unfortunate folks who develop end-stage or Stage 4 sarcoidosis can require a lung transplant, can't they?

A. That's true. Some of them can. Not all of them.

Q. And you've never had a patient that needed to go have a lung transplant, have you?

A. Not that I know of.

Q. And you've never published anything on the topic of sarcoidosis, have you?

A. No.

Q. Either the radiographic interpretations of it or any other aspect of it?

A. Just made studies as a medical student and resident would, and seen them in presentations and made presentations as a resident, but not anything formal at a large meeting or a publication.

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Q. You've never --
A. It's a common disease --
Q. Excuse me?
A. It's a common disease that we learn about as a radiology resident, because it's important for the radiologists to help consider that in the differential to exclude cancer or lymphoma because of the bilateral hilar adenopathy.
Q. And you don't claim to have any knowledge of whether there is or is not an association between cigarette smoking and sarcoidosis?
A. Could you say that again? I don't know what?
Q. You don't claim to have any knowledge of whether or not there is an association between smoking and sarcoidosis?
A. Not specifically, no.
Q. The initiation of the illness or its progression, correct?
A. How does that relate to the -- does it relate to the other question you just asked?
Q. Yes. You have no particular knowledge about that, do you?
A. About the relationship between smoking and sarcoidosis?

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Q. Yes.
A. Whether it does or does not cause it?
Q. Correct.
A. Is that what you mean?
Q. Yes.
A. Yes. I think no particular knowledge to a significant degree.
Q. No one does, do they?
A. Not that I know of, no.
Q. Again, no one knows what causes it or why it progresses in people, do they?
A. No.
Q. Let's talk about how sarcoidosis looks or can look on an X-ray. It can have -- it can appear as hilar or mediastinal lymph adenopathy, commonly bilateral, right?
A. Yes.
Q. And that's what you've been talking to these folks on the jury about today, bilateral hilar lymph adenopathy?
A. Correct.
Q. And that starts here, sort of in the middle of your chest, and spreads out this way, doesn't it?
A. No, sir.

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Q. How does it go?

A. Well, the very first stage as we discussed is bilateral hilar adenopathy and peritracheal adenopathy, and that would be considered Stage I. And in patients with Stage I sarcoid, there are statistics that say about 70 to 90 percent of people will have spontaneous remission.

And so it doesn't -- so that it may present and totally go away.

Q. It could?

A. No one can predict who that will be, but a majority of people that present as Ms. Fontana did, the expectation is that a high percentage of those people will spontaneously remit or go away.

Q. Unfortunately, that didn't happen with Ms. Fontana; did it?

A. That's true. That's true.

Q. But no one --

A. There is no way to predict -- there is no special test that one could predict it one way or the another.

Q. And no one knows why it progressed in Ms. Fontana, do they?

A. That's correct.

Q. Sarcoidosis can result in noncaseating

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granulomas or nodular changes forming?

A. Miliary nodular changes, first of all, which are very tiny nodules, in the one-millimeter range.

Q. Those are like bumps, right?

A. It depends on your definition of what a bump is, but the classic definition is miliary, because it relates to a millet seed, which is a very tiny dimension of about one to 1.5 millimeters in size. And it's also a common word that is used to describe the nodules that first appear in the lung fields in tuberculosis.

There is a terminology such as miliary TB, which is when you see multiple tiny nodules scattered throughout the lung fields.

Q. And those nodules can grow in size?

A. They don't actually grow in size. What happens is as they -- as you get more and more nodules present within the interstitium, they can become conglomerate masses, and so it presents as if you're seeing a mass; but when you actually break it down and look at it, it's the conglomerate of all those tiny miliary nodules, or it can present as ground-glass opacity, which means essentially if you ground glass up into tiny sand-like particles and

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present it on the lung fields, you would see this hazy veil of opacification over the lung fields, and what they have found is that ground-glass opacity is actually due to the small miliary nodules within the lung fields.

So it's one and the same process, but given two different descripter names.

Q. These miliary nodules, do they continue to spread?

A. Well, if it progresses, it can.

Q. Is that what happened in Ms. Fontana?

A. I think so, yes.

Q. It started in the hilar region?

A. Right.

Q. Did it also start in the peritracheal region?

A. Yes. That's the first presentation classically of sarcoidosis, which is classified as a Stage I.

Q. Your trachea is just like my tie, right, it comes right down here?

A. Just like your tie.

Q. Maybe not as pretty as my tie?

A. The trachea is not yellow, I don't think, but it's in the midline, yes, I agree.

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Q. All right. And so in this lady, her miliary nodules began right here, right down the middle of her chest, right?

A. No, that's not correct.

Q. Where do you think they started?

A. I think you're confusing two things. The sarcoidosis, what you're seeing in that very first stage, where we're talking about the lymph adenopathy and the hilum and mediastinum, you're actually seeing enlargement of the lymph nodes. You're not seeing millet seeds or tiny miliary nodules in the lymph nodes; you're actually seeing inflammatory changes of the lymph nodes.

Then when you say it spreads out, it's not coming out of the lymph nodes. Then the second stage -- excuse me -- the second stage of sarcoidosis is when you see both hilar adenopathy and the presence of miliary nodules or infiltrates in the lung fields.

So it's not that it's spread out; that's just considered to be a second stage, is when you finally see lung involvement itself by these tiny miliary nodules in the interstitium.

Q. All right. So there's not really a spreading effect; it's just a second appearance of

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some other change in the lung?

A. Yes, sir.

Q. First it's in the lymph nodes, and then it's in these nodules, these miliary nodules, in the lung field itself?

A. Yes, sir.

Q. And then it can have interstitial changes, right?

A. Well, that would be -- when the miliary nodules are in the interstitium, then that would be considered interstitial changes.

Q. Where is the interstitium in the lung?

MR. REILLY: Do you have that diagram?

May I borrow it?

MR. GERSON: Use any of the diagrams.

BY MR. REILLY:

Q. Which would depict best what you're talking about?

A. The one with the blood vessels on it I think would be the best one.

No, not that one. That's the bronchi. The one with the blood vessels.

Q. Doctor, let's talk about where the interstitium is.

Where is the sarcoidosis when it spreads

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to the interstitium?

A. Well, the interstitium are the spaces that can be seen in between these air sacs that we're talking about, the alveoli.

So, for instance, these white spaces that we're seeing that aren't drawn in with other alveoli, those tiny separating spaces is the interstitium, which is basically a small fibrous network that helps support the structure such as the alveoli within the lung fields.

Q. And what physically happens when sarcoidosis begins to spread into the interstitium?

A. Well, you begin to see the changes on the radiograph of opacity, whether you're seeing the ground-glass opacity or you're seeing the miliary nodules within the interstitium.

Q. That's the appearance. Do you know what is physically happening to the tissue in here?

A. Well, it's being compressed by those nodules. It's space-occupying. So it would be occupying some space within the lung fields.

Q. Are these nodules round or roundish?

A. Roundish, yes.

Q. Do they appear that way on chest films?

A. If you can get a good chest film to

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resolve it to that degree. Usually what you see are the effect that those tiny nodules cause within the lung fields, which are to see linear opacity, which are considered to be interstitial changes from the coalescence of multiple nodules in line form of the interstitium.

Q. Does that compromise these alveoli's ability to perform their function, the gas exchange?

A. Ultimately when that interstitium becomes fibrotic, it will do that, yes.

Q. And in Ms. Fontana, the fibrotic changes due to sarcoidosis are extensive in her lung, aren't they?

A. In the end stage, of course, the later years.

Q. Which is where she is today?

A. Yes. The 2000 films, I think we can see that very easily.

Q. And it has severely compromised her lung's ability to perform that gas exchange that normally occurs in the alveoli, correct?

A. Well, it's probably a combination that when you get the interstitium change, it becomes fibrotic; they develop essentially a restrictive lung disease where they cannot -- the lung becomes

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actually hard. They cannot expand their lungs and they cannot contract their lungs very well, so it eventually involves poor gaseous exchange, because the lung just isn't as compliant anymore and cannot open and close like it used to.

Q. And that's what sarcoidosis does to you?

A. Correct.

Q. Thank you, Doctor.

It can also have a radiographic appearance of opacity in the lung, which you described earlier as that ground-glass appearance, correct?

A. Yes, sir.

Q. Is that's what's going on that creates the opacity, or is that something else that you just described?

A. No, it's what I described before, the miliary nodules that you're seeing. Remember, you're seeing those not as just one nodule but many of them superimposed, so it creates an overall additive effect that you see an opacity, because you or I cannot pick out the individual ones.

Q. It can create -- I'm sorry. It can have the radiographic appearance of cavitation; can't it?

A. Yes.

Q. What is that?

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A. Cavitation is where you get areas of fibrosis and things begin to retract where you can get cavities to form.

Q. And you found evidence of cavitation radiographically?

A. There is some, yes.

Q. And you conclude that that was due to Ms. Fontana's sarcoidosis, correct?

A. No, not all of it.

Q. We'll get to that.

The X-ray appearance can demonstrate mycetoma?

A. Yes, sir.

Q. What is mycetoma, for the jury?

A. Mycetoma is basically a fungus, another name for a fungus ball in the lung, usually occurring inside of a cavity.

Q. And there was evidence of that in Ms. Fontana's X-rays, correct?

A. Yes, sir.

Q. And you concluded that was due to sarcoidosis, correct?

A. It was most likely due, in part, to her treatment from the sarcoidosis. I believe she was placed on steroids, which then makes the patient

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immunocompromised, and they can no longer fight off the normal fungi that most of us would be exposed to. So now if there is a cavity present, some of that fungus that we would normally fight off, she cannot fight off because she's immunocompromised, and it can grow within the cavity.

Q. So the sarcoidosis actually has a secondary -- creates a secondary problem, and that is when you treat it, the treatment can give rise to new problems, correct?

A. Yes. That's true.

Q. And the new problem can be that it sets up a situation where a new disease takes over in the lung, in addition to what's going on, simply due to the sarcoidosis, correct?

A. Correct.

Q. And in this case, in Ms. Fontana's case, what happened was the fungus, known as aspergilloma, did I -- you and I have pronounced this differently.

A. I want to hear your pronunciation.

Q. Well, I'm going to try aspergill --

A. I think aspergilloma is the overall term for the fungus ball that we're seeing or you can use the word fungus ball. We know we're talking about the aspergillus fungus variety.

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Q. Mycetoma is sort of an umbrella for fungus ball, because there are different types of fungus. But she happens to have an aspergilloma, correct?

A. Correct.

Q. Those things are hard -- can you actually effectively treat them?

A. They're very difficult to treat, because obviously the fungus ball is sitting in a cavity and it's not receiving a well-defined, independent blood supply where you could get an antibiotic into it through the blood supply, so they're difficult to treat.

Q. Sarcoidosis in end stage is a tough disease, isn't it?

A. It can be.

Q. And in Ms. Fontana it's a tough disease, isn't it?

A. Particularly since she has a superimposed problem going on besides the sarcoidosis.

Q. We'll talk about that.

A. I'm sure you will.

Q. Doctor, scarring is radiographically apparent oftentimes in sarcoidosis, especially in apices; correct?

A. Yes.

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Q. And apices are where?
A. The upper lung fields.
Q. Top of the lungs, right?
A. Top of the lungs.
Q. And Ms. Fontana has that, doesn't she?
A. Yes.
Q. And her scarring is extensive, isn't it?
A. She has interstitial scarring throughout her lungs, and also apices.
Q. As a matter of fact, we were talking a minute ago about fungus, because she has two major fungus ball sites, right?
A. Yes.
Q. One in the left lung; one in the right lung, right?
A. Correct.
Q. Not too long ago she only had one?
A. Yes.
Q. Now she has two?
A. Yes.
Q. Ms. Fontana has blebs, right?
A. Correct.
Q. And she has bullae?
A. Correct.
Q. Due to her sarcoidosis, correct?

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A. Not correct.
Q. All right.
A. Not entirely correct, because the bullae and blebs can also be caused by the emphysema.
Q. In this case, do you hold the opinion that her blebs and bullae are due to sarcoidosis?
A. I think we can look at the films and be able to help differentiate which ones are and which ones aren't.
Q. You've looked at the chest X-ray of 2/6/01, correct?
A. I would have to look at it again to know if I have it or not. I'm not sure.
MR. REILLY: Can I see that?
THE COURT: It's 2 something.
THE WITNESS: Did we review this this morning?
BY MR. REILLY:
Q. At the time I took your deposition, did you have the February -- do you remember preparing this exhibit, Doctor, 2/6/01?
A. Yes.
Q. You didn't review that today with -- or did you review that today?
A. Yes, we did review it. That's the one

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where I describe that the nodule in the left upper lobe had gotten larger and appeared to have a lucent septation between -- running through the middle of it, and there was also an opacity in the right upper lobe, which looked like a fungus ball might be developing in that area, as well.

THE COURT: Doctor, in the right-hand corner of that exhibit is a number. Would you read it?

THE WITNESS: 2-H.

THE COURT: Thank you.

BY MR. REILLY

Q. Now, Doctor, you see changes in her X-ray which are consistent with a lady -- in that X-ray, you see changes that are consistent with a lady who was suffering from very advanced sarcoidosis, correct?

A. Yes.

Q. And included in her problems now is a substantially restricted lung, correct?

A. I believe so, yes.

Q. You see the hilar adenopathy?

A. Yes.

Q. You see scarring, especially in the apices of the lung?

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A. Yes.
Q. You see the presence of bullae and blebs?
A. Correct.
Q. You see a mycetoma on the left?
A. Yes.
Q. You see one on the right, in that X-ray?
A. Correct. I see an opacity that could be one. I'd have to see a CT to be sure.
Q. You see interstitial and nodular changes?
A. Yes.
Q. And all those things are related most probably to her sarcoidosis, correct?
A. I would take deference to the bullae and blebs. The other things I think I've described as well as changes secondary to sarcoidosis.
Q. Doctor, would you please turn to Page 153 of your deposition from a week ago.
A. 153?
Q. Yes. Line 21.

Read along with me, if you would. Line 21:

"Question: 2/6/01, you see changes in her X-ray that are consistent with a lady who is suffering from very advanced sarcoidosis, correct?

"Answer: It appears so, yes.

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"And included in those are now a substantially restricted lung, correct?

"Answer: Yes.

"Question: You see the hilar adenopathy?

"Answer: Yes.

"You see scarring, especially in the upper apices of the lung, correct?

"Answer: Yes.

"Question: You see the presence of bullae and blebs, correct?

"Answer: Yes.

"Question: You see a mycetoma on the left, correct?

"Answer: Correct.

"Question: Do you see one on the right in that X-ray?

"Answer: Well, there is an increased opacity in the right apical lung field, as well, so what's difficult to determine at this time is some type of consolidating infiltrate, or if there is, you know, some mass developing up there, as well.

"Question: All right. You see interstitial and nodular changes, correct?

"Answer: Yes.

"Question: All right. And all those

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things are related most probably to her sarcoidosis, correct?

"Answer: Correct."

Those are the questions I asked and the answers you gave?

MR. HUNTER: I think he needs to read the next question and answer, Judge, in all fairness.

THE COURT: Okay.

MR. HUNTER: I'll read it.

MR. REILLY: Sure. I'll read it.

Q. "Question: All right. Now, in addition to that, on the 2/6 X-ray you see peribronchial thickening, correct?

"Answer: Correct."

Those are the questions I asked and the answers you gave?

A. Right.

Q. So a week ago you said the blebs and bullae were most probably related to the sarcoidosis, correct?

A. Well, the way it's related to the way you've listed these questions, that's correct, but I would venture to say if you re-summarized all those questions, I would not agree to the totality of the

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bullae and blebs, because you got me into a format where you're saying, question, correct, question, correct, question, correct.

Once you go through a series of eight of those, it's easy to summarize, and after I also interjected a little answer about the opacity in the right upper lobe, and when you asked the question, is adenopathy interstitial, this, that and the other all related to sarcoidosis, I said, "Correct."

If you asked specifically, and you did not ask specifically, because up at the top, you said "You see the presence of bullae and blebs," and my answer is, "Correct. Yes, I do."

We did not discuss at that time whether I agreed that it was secondary to sarcoidosis or not. Then you moved a bunch of lines down and then re-summarized the whole thing and say, "Is that all related to sarcoidosis," and everything that you said I felt is related to sarcoidosis, not the blebs and bullae, but I didn't remember it that way, as you asked that question 10, 12, 15 lines ago.

And I disagree with that in the way that it was answered.

Q. What you're saying is --

A. Because I -- and I think I have stated

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before in my testimony that the bullae and blebs in this lady are not solely due to her sarcoidosis. And I could show you on the X-ray how you can tell the difference between that, when you're so interested in finding out that difference.

Q. Doctor, you review a hundred medical cases a year?

A. Yes, sir.

Q. You give 25 to 35 depositions a year?

A. Yes, sir.

Q. And you're done it for 13 or 14 years?

A. Yes, sir.

Q. You're saying I kind of tricked you with this question, humn?

A. I did not use the word "tricked." I'm explaining how I would look at a series of 7 or 8 questions along with an answer interjected, and I stand by what I'm saying today to this jury, that bullae and blebs are not solely caused by sarcoidosis. And it is much more common when a person has bullae or blebs in their lung, in the absence of sarcoidosis, for that bullae or bleb to be caused from smoking.

And that is perfectly acceptable, and that is the way it happens. This person --

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Q. But a week ago --

A. As I explained to the jury, this person has a combination of both disease processes going on, and, yes, they do have bullae and blebs.

Q. Doctor, would you turn to Page 64?

You know what, Doctor, what I want to do is turn to the 1989 X-ray that you put up.

Let's talk about your interpretation of the 1989 X-ray. Looking at the X-ray today, did you look at the interpretation of that X-ray that was made by Dr. Greene?

A. For her 1989 X-ray?

Q. Yes.

A. I don't believe I've ever seen the 1989 X-ray interpretation.

Q. All right.

A. At least I don't have it in my packet of X-ray interpretations that I was able to pull out from the medical records.

Q. Doctor, today you said that --

MR. REILLY: Do you have that X-ray?

MR. GERSON: We have them. Which one?

MR. REILLY: '89.

Q. Doctor, everything on that X-ray is consistent with sarcoidosis, isn't it?

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A. Well, I'm going to be very careful of your words, because you choose them carefully. I'm not going to say everything on that X-ray is consistent with sarcoidosis.

I think there are findings on this film that are consistent with sarcoidosis.

Q. Are there any findings on that film inconsistent with sarcoidosis?

A. Well, I think there's another disease process on these films. I think the findings, as I see them, I would consider the findings are -- have a radiologic appearance of sarcoidosis, as one of the findings on the film.

Q. Doctor, a week ago did you see anything remarkable enough on this X-ray to make a diagnosis of another disease process, on this X-ray?

A. Well, I talked about hyperaeration of the lungs, in 1989, and I talked about that again today. And I talked about peribronchial thickening, I think on several of the films. I don't know if I talked about it on this one specifically.

Q. We'll talk about that in a minute.

Doctor, why don't you resume your seat, and let me ask you, a week ago at Page 93 at Line 13, I asked you: "Question: That's exactly what I

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wanted to know. Any findings on that film inconsistent with sarcoidosis?" to which your answer was: "Inconsistent? No. Not necessarily."

"Question: Any findings on that film consistent with the disease process other than sarcoidosis, a disease process of the lungs, other than sarcoidosis?" to which you answered: "Well, there could be. I just don't see anything to remark on at this time. I mean, you can have a disease process of the lungs that you may not -- that may not be obvious on the chest films."

Is that the questions that I asked you and the answers that you gave a week ago?

A. Yes.

Q. And today, you said you see peribronchial thickening on this X-ray, correct?

A. Correct.

Q. Would you turn with me to Page 98, Line 4. I asked you at Line 4:

"You didn't see evidence of diffuse peribronchial thickening on the 5/12/89 film, correct?

"Answer: Correct.

"Question: So this would be a change that occurred between 5/12/89 and 1/29/90, correct?

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"Answer: Yes."

So a week ago you didn't see peribronchial thickening, but today you do?

A. I think there is some -- as I study it more, yes. And you didn't read on Page 92, where a week ago I did discuss the lungs appear mildly hyperaerated, and there is increased interstitial and reticular nodule densities at both lung bases and also the apical lung fields.

Q. Those are consistent with sarcoidosis, right?

A. No. The hyperaeration is not consistent with sarcoidosis.

Q. Yes. And a week ago you agreed with me that might be simply because this lady required a bigger breath of air, right?

A. I didn't agree with you. You didn't offer that. I offered that --

Q. Okay.

A. -- as a change. I mean, I see what you're trying to do with your questions, sir.

MR. REILLY: Your Honor, I object.

THE COURT: Hold on one second. He asked the question, so you have to answer it.

THE WITNESS: Okay. That's fine.

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BY MR. REILLY:

Q. As a matter of fact, a week ago you indicated you saw hyperaeration on this film, and then six months later you indicated you would not have diagnosed hyperaeration on the next film, correct?

A. Correct, because I think, as I explained, there were other things going on in the lung fields, and the lungs didn't appear as overall hyperaerated as they did on the 1989 film.

Q. Let's take a look at the interpretation made of this 1989 film by Dr. Greene.

Can we pull that out?

It says -- this is in the medical records, but it's not in your records.

A. Probably because -- is that an official chest X-ray report by a radiologist or is that an X-ray record by a pulmonologist or someone else who entered it into their own medical record?

Q. This is a record of a board-certified pulmonologist.

A. But not a radiologist.

Q. And not a radiologist.

A. Okay. That's probably why I don't have it.

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Q. All right. Were you given it?

A. I have no idea. As I told you before, I couldn't tell you the names of the doctors who were her treating physicians, because it was not of importance to me. It was important for me to look at the chest X-rays and CT scans and interpret them myself.

Q. All right. This interpretation of the chest X-rays show bilateral hilar adenopathy and interstitial fibrosis, correct?

A. Yes, sir.

Q. No mention of peribronchial thickening, correct?

A. Yes, sir.

Q. No mention of hyperaeration?

A. Yes, sir.

Q. No mention of anything unrelated to her sarcoidosis, correct?

A. Well, yes, sir, and I would have to say that is a very brief chest X-ray report, if that's what one is going to consider, a one-sentence dictation on someone's chest X-ray. That is not the dictation of a radiologist; I can tell you that much.

Q. But no mention of hyperaeration, correct?

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A. Well, he only has, what, about ten words in his dictation of that chest X-ray, and he didn't choose to put hyperaeration in there. He didn't choose to put centrilobular emphysema in there. He didn't put --

Q. Well, you chose these X-rays to show the jury, didn't you?

THE COURT: Excuse me. Let him finish his answer.

MR. REILLY: I thought he was.

A. He didn't choose to put peribronchial thickening or any one of a number of things that could have been listed, as well, in the interpretation.

He put a very succinct sentence that talked about two things that support a diagnosis of sarcoidosis and doesn't discuss anything else.

He didn't include, for instance, in there a differential that when you see hilar adenopathy or peritracheal adenopathy, you cannot exclude the possibility of cancer based on a single chest film.

He didn't rule out lymphoma. He did not rule out cancer of the lung.

So, that is a very succinct, short and, in my opinion, inadequate dictation of a chest X-ray by

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a nonradiologist.

Q. Did you look at a radiology report from a radiologist in 1989?

A. I don't believe I have any radiology reports from 1989.

MR. REILLY: How do I switch this over? I need some technical help here. I am technically-challenged.

We need you to make that look good.

I'm sorry for the delay.

Let's identify it first. Did you put a number on it for identification?

THE CLERK: I believe that's A-4. Is that part of the radiology reports?

MR. REILLY: Yes.

THE CLERK: That's A-4 for identification for Defendant Phillip Morris.

Q. This is a radiology report from a radiologist, correct?

Is that clear to everybody?

Thank you. It's a radiologist report --

THE COURT: Let's give the doctor the actual exhibit so he can look at it.

THE CLERK: He has them, Judge.

THE COURT: Let him look at it.

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MR. REILLY: I have another set.

Here you go, Doctor.

BY MR. REILLY

Q. Doctor, that's a radiology report from a radiologist, right?

A. Yes, sir.

Q. And it is dated 9/4/89, right?

A. Yes.

Q. The X-ray that you put up -- you chose this X-ray to show to this jury, right?

A. Yes, sir.

Q. And it is dated May 12th, 1989, right?

A. Yes, it is.

Q. So this radiologist is looking at a chest X-ray taken about five months later?

A. Correct.

Q. Four or five months later?

A. Yes.

Q. And he writes: "The cardiac silhouette is within normal limits. There is bilateral hilar adenopathy." That's part of the sarcoidosis, right?

A. Right.

Q. "The lungs are free of infiltrates or edema. Regional bones and soft tissues are intact. Compared to 2/21/89, there has been little interval

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change.

"Impression: Bilateral hilar adenopathy consistent with the known diagnosis of sarcoid," correct?

A. Yes, sir.

Q. Now, there is a board-certified radiologist --

MR. HUNTER: Judge, I object to this.

THE COURT: Sustained.

BY MR. REILLY

Q. There is a radiologist, right?

A. Yes, sir.

Q. You don't know whether he's board-certified or not?

A. No, sir.

Q. You don't know Dr. Jalens from West Boca Medical Center, do you?

A. No, sir.

Q. That's a hospital right up the road here, isn't it?

A. I have no idea.

Q. Do you know where Boca Raton?

A. I know it's on the east coast. I'm not familiar with where it is. I live on the west coast.

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Q. You're over in Tampa?
A. Don't come over here very often.
Q. All right. Here is a physician who makes no mention of peribronchial thickening, a radiologist, right?
A. Could you say that again?
MR. HUNTER: Your Honor, I would like to approach the bench at this point.
THE COURT: Yes, sir.
(The following proceedings were had at sidebar:)
MR. HUNTER: Judge, he can put an X-ray up there, but as soon as he starts going into personalities and locations and throws out things that aren't established in the record, such as board-certified, then he's essentially asking one expert to comment about the opinion of another expert, and that's inadmissible and I object to it.
MR. REILLY: That's completely incorrect. This is not an expert in this case. I'm asking him to comment on a comparison between his opinions and the opinions of the radiologist who took this X-ray, interpreted this X-ray in 1989. I'm absolutely permitted to do that.

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MR. HUNTER: He's asking does he know where Boca Raton is.

THE COURT: Whether he's board-certified, do you know whether he's board-certified. Do you know?

MR. REILLY: I do know he's board-certified, sure. You don't think Boca Raton allows people not board-certified?

THE COURT: I don't care, frankly.

MR. REILLY: I'll ask you to take judicial notice. I'll bring it tomorrow. Not a problem.

THE COURT: You're not allowed to testify anyway. You can't do it. It doesn't make any difference. Let's keep the extraneous stuff out of it.

MR. REILLY: No problem.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

BY MR. REILLY:

Q. Let's be succinct about this. Dr. Jalens makes no mention of peribronchial thickening, correct?

A. Yes, sir.

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Q. He makes no mention of emphysema, correct?
A. That is correct.
Q. He makes no mention of any disease process, other than those consistent with the diagnosis of sarcoid, correct?
A. I think it's probably a lady. You keep saying "he," but it's Lori. I'm assuming it's a lady. But that's fine.
Q. You're probably right.
A. I'll agree.
Q. Do you have any idea why you weren't given this report to review?
A. As I said before, I don't think I was given a report specifically to review. They wanted my opinion regarding the X-rays, and I did not -- I don't know if I even looked at the 9/4/89 film. I looked at the 5/12/89 film. I don't think it was withheld. I didn't feel like I ever needed to see it.
Q. Doctor, let's look at another radiology report from the next day. This is 9-5-89, correct?
A. Yes, sir.
Q. Again, at the West Boca Medical Center, correct?
A. Yes, sir.

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Q. This time the chest film is being interpreted by Dr. Lee Katims, correct?

A. Yes, sir.

Q. I may be horrible at pronouncing these names.

A. I think it's Katims, actually.

Q. You know him?

A. I've heard of him.

Q. Is he a board-certified radiologist?

A. I don't know.

Q. He makes an interpretation of the chest film on that day, as well, next day, right?

A. Yes, sir.

Q. His interpretation is: "Bilateral hilar enlargement is present. The lungs are clear. Heart size normal. Bones intact.

"Impression: Bilateral hilar enlargement, consistent with the patient's diagnosis of sarcoidosis. No change from 9/4/89," right?

A. Yes, sir.

Q. No peribronchial thickening?

A. Correct.

Q. No emphysema?

A. Nothing mentioned.

Q. No hyperaeration?

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A. Nothing mentioned.

Also, the other thing that he didn't mention, and neither did Lori, the other doctor, is they did not mention, either one of them, right peritracheal adenopathy, which I represent to the jury is present on the 5-12-89 film, but neither one of them mentioned that, like they didn't mention peribronchial thickening, just like they didn't mention hyperaeration, just like they didn't mention centrilobular emphysema.

Q. Doctor, here is Lori Jalens again on 9/13/89, correct?

A. Well, I can't see the bottom, but I'll take your word for it that that's her.

Q. I'll show you. Dr. Lori Jalens. You don't have to take my word for it.

A. Okay.

Q. So now we're about nine -- a week later, roughly?

A. Yes, sir.

Q. Now, these are not doctors involved in litigation, are they?

A. No, sir.

Q. They haven't been hired by the plaintiff to present testimony to this jury, have they?

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A. Correct.

Q. They're just calling these radiographs as they see them, in caring for the patient, aren't they?

A. Correct.

Q. On this day, Dr. Jalens says -- she's got two views, and she says: "Posterior, anterior and lateral view of the chest reveal a normal size cardiac silhouette. There is bilateral hilar adenopathy. Increased interstitial markings are noted in the lung apices. Surgical clips are seen in the mid abdomen.

"Impression: Bilateral hilar adenopathy, with interstitial lung changes. Clinical correlation is suggested."

All those conditions are consistent with her sarcoidosis, aren't they?

A. Except for the fact, as you point out, she didn't mention peribronchial thickening. She didn't mention emphysematous changes or centrilobular emphysema. She did not mention right peritracheal adenopathy, which is consistent with sarcoidosis.

So those are all omissions of findings that are present on the film that she did not mention, that is correct.

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Q. They are findings that you made, but she doesn't report?

A. Well, eventually I think people do begin to mention right peritracheal adenopathy, which is back present on the 1989 film, and probably on those films, although I cannot remember them off the top of my head, and were also present but not mentioned on the report; the point being is that not every radiologist will mention every single finding to come to a conclusion on their report.

Q. Doctor --

THE COURT: Are we going to another film?

MR. REILLY: Another film. Another film, same hospital.

THE COURT: It's 5:00. You're been working the last two days much longer than I think you should be.

What I'm going to do now is recess for the evening.

If we could finish in 15 minutes, I would probably keep you. I don't think we would finish in 15 minutes.

What I'd like you to do is remember my instructions. I haven't seen any -- I saw a video cameraman here this morning, but I

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haven't seen any video camera people here today. Just remember my warning about reviewing, looking at the paper, and if you see something -- I want you to read the paper if you read the newspaper, but if you see something about this case, don't read it.

Other than that, just enjoy a good evening. And see if you can come about the same time, 9:45 tomorrow. We'll try to put in a full day, keep on plugging.

So just have a good evening, and we'll see you tomorrow.

Leave your note pads in the seat, and we'll collect them and give them to you tomorrow.

(The jury exited from the courtroom.)

MR. REILLY: Your Honor, I would only request that you give the admonition to the witness.

THE COURT: I did when we broke the first time. He still remembers.

MR. REILLY: Thank you, Your Honor.

THE COURT: Doctor, thank you very much.

THE WITNESS: Thank you, sir.

THE COURT: Anything else?

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MR. HUNTER: Judge, what is the rule about talking to an expert during the break or during the trial. Is that prohibited or allowed?

THE COURT: During a trial you're not allowed. During his testimony, you're not allowed to, as I understand, not allowed to talk to him about the subject matter of the examination.

MR. HUNTER: Okay.

THE COURT: Talk to him about anything else. Talk about the Yankees, Dolphins, whatever you want to. That's my understanding of the rule.

Anything else?

MR. REILLY: No, Your Honor.

THE COURT: We'll be in recess until tomorrow at 10:00.

(Court was adjourned at 5:00 p.m.)

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